Check the appropriate company.

Authorization

Proposed Insured: _____

☐ Metropolitan Life Insurance Company ☐ MetLife Investors USA Insurance Company
☐ New England Life Insurance Company ☐ General American Life Insurance Company
☐ MetLife Investors Insurance Company ☐ Metropolitan Tower Life Insurance Company

The Company indicated above is referred to as "the Company".

This form was designed to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) rules.

For underwriting and claim settlement purposes regarding me or any child(ren) under the age of 18 named below,

I authorize:

- Any medical practitioner; any medical facility; any other medical entity; any insurer; any consumer reporting agency; and the MIB Group, Inc. (MIB) to give the Company information about me or such child(ren), including:
  - personal information and data,
  - entire medical file for the last ten (10) years, including medical information, records, and data (such as: office visits; patient treatment; hospitalization; drugs prescribed; medical test results; information about sexually transmitted diseases and other similar information);
  - information related to alcohol and drug abuse and treatment;
  - information, records and data relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, including Human Immuno-deficiency Virus (HIV) test results; and
  - information, records and data relating to mental illness.
- The Company to redisclose information received pursuant to this Authorization as authorized by me in writing or as otherwise permitted by applicable law.
- The Company to request and obtain: consumer; investigative consumer; or motor vehicle reports.
- Any employer, business associate, financial institution, or government agency to give the Company any information or data that it may have about: occupations; avocations; driving record; finances, character; reputation; and aviation activities.

I understand that:

- Information, records and data that the Company receives pursuant to this Authorization will be used and maintained by the company as described in the Company's Privacy Notice, a copy of which was given to me
- All or part of the information, records and data that the Company receives pursuant to this Authorization may be disclosed to MIB. Such information may also be disclosed to and used by: any reinsurer; any Company employee; or any affiliate or independent contractor who performs a business service for the Company on the insurance applied for or on existing insurance with the Company. Information may also be disclosed as otherwise required or permitted by applicable laws.
- Information related to alcohol and drug abuse that has been disclosed to the Company may be protected by Federal Regulations 42 CFR part 2. This information may be redisclosed as provided in this Authorization.
- Medical information, records and data disclosed may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, 45 CFR Parts 160-164. These rules set forth standards for the use, maintenance and disclosure of such information by health care providers and health plans. Once disclosed to the Company, this information may no longer be subject to those laws or regulations.
- Information obtained pursuant to this Authorization about me or such child(ren) may be used, to the extent permitted by law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- If underwriting determines that an investigative consumer report is needed, I will be contacted by the consumer reporting agency and interviewed in connection with its preparation.
- I am not required by law to sign this Authorization, but if I do not, the Company will not be able to underwrite my application for life insurance. In addition, health care provider(s) or health care plan(s) asked to release information pursuant to this Authorization can not condition treatment or payment for treatment or other benefits on my signing it.
- This Authorization will end 24 months from the date on this form or sooner if prescribed by law. I may revoke it at any time by writing to the Company and advising it that I have revoked this Authorization. Any action taken before the Company has received my revocation will be valid.
- I have a right to receive a copy of this form.

A photocopy of this form is as valid as the original form.

SIGNATURES:

(If a Proposed Insured is under age 18, the Parent or Guardian, (circle one) is to sign on line for such child.)

Proposed Insured #1 Allen S. Lapides Date 11/11/07

Print Name of Proposed Insured #1 Allen Lapides Date of Birth 6-19-31

Proposed Insured #2 _____ Date _____

Print Name of Proposed Insured #2 _____ Date of Birth _____

Witness [illegible] Date 11/11/07

EAUTH-05 (05/05) ef

Check the appropriate company.

Authorization

Proposed Insured: _____

☐ Metropolitan Life Insurance Company ☐ First MetLife Investors Insurance Company
☐ New England Life Insurance Company ☐ Metropolitan Tower Life Insurance Company

The Company indicated above is referred to as "the Company".

This form was designed to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) rules

For underwriting and claim settlement purposes regarding me or any child(ren) under the age of 18 named below, I authorize:

- Any medical practitioner; any medical facility; any other medical entity; any insurer; any consumer reporting agency; and the MIB Group, Inc. (MIB) to give the Company information about me or such child(ren), including:
  - personal information and data;
  - entire medical file for the last ten (10) years, including medical information, records, and data (such as: office visits; patient treatment; hospitalization; drugs prescribed; medical test results; information about sexually transmitted diseases and other similar information);
  - information related to alcohol and drug abuse and treatment;
  - information, records and data relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions; and
  - information, records and data relating to mental illness.
- The Company to redisclose information received pursuant to this Authorization as authorized by me in writing or as otherwise permitted by applicable law.
- The Company to request and obtain consumer, investigative consumer, or motor vehicle reports.
- Any employer, business associate, financial institution, or government agency to give the Company any information or data that it may have about: occupations; avocations; driving record; finances; character; reputation; and aviation activities.

I understand that:

- Information, records and data that the Company receives pursuant to this Authorization will be used and maintained by the company as described in the Company's Privacy Notice, a copy of which was given to me.
- All or part of the information, records and data that the Company receives pursuant to this Authorization may be disclosed to MIB. Such information may also be disclosed to and used by: any reinsurer; any Company employee; or any affiliate or independent contractor who performs a business service for the Company on the insurance applied for or on existing insurance with the Company. Information may also be disclosed as otherwise required or permitted by applicable laws.
- Information related to alcohol and drug abuse that has been disclosed to the Company may be protected by Federal Regulations 42 CFR part 2. This information may be redisclosed as provided in this Authorization.
- Medical information, records and data disclosed may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, 45 CFR Parts 160-164. These rules set forth standards for the use, maintenance and disclosure of such information by health care providers and health plans. Once disclosed to the Company, this information may no longer be subject to those laws or regulations.
- Information obtained pursuant to this Authorization about me or such child(ren) may be used, to the extent permitted by law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- If underwriting determines that an investigative consumer report is needed, I will be contacted by the consumer reporting agency and interviewed in connection with its preparation.
- I am not required by law to sign this Authorization, but if I do not, the Company will not be able to underwrite my application for life insurance. In addition, health care provider(s) or health care plan(s) asked to release information pursuant to this Authorization can not condition treatment or payment for treatment or other benefits on my signing it.
- This Authorization will end 24 months from the date on this form or sooner if prescribed by law. I may revoke it at any time by writing to the Company and advising it that I have revoked this Authorization. Any act on taken before the Company has received my revocation will be valid.
- I have a right to receive a copy of this form.

A photocopy of this form is as valid as the original form.

SIGNATURES:

(If a Proposed Insured is under age 18, the Parent or Guardian (circle one) is to sign on line for such child.)

Proposed Insured #1 Lola Lieber-Schwartz Date 12/18/2007

Print Name of Proposed Insured #1 Lola Lieber-Schwartz Date of Birth 03/15/1923

Proposed Insured #2 _____ Date _____

Print Name of Proposed Insured #2 _____ Date of Birth _____

Witness _____ Date 12/18/2007

Check the appropriate company.

Authorization

Proposed Insured: _____

☐ Metropolitan Life Insurance Company ☐ First MetLife Investors Insurance Company
☐ New England Life Insurance Company ☐ Metropolitan Tower Life Insurance Company

The Company indicated above is referred to as "the Company".

This form was designed to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) rules.
For underwriting and claim settlement purposes regarding me or any child(ren) under the age of 18 named below,
I authorize:

- Any medical practitioner; any medical facility; any other medical entity; any insurer; any consumer reporting agency; and the MIB Group, Inc. (MIB) to give the Company information about me or such child(ren), including:
  - personal information and data;
  - entire medical file for the last ten (10) years, including medical information, records, and data (such as: office visits; patient treatment; hospitalization; drugs prescribed; medical test results; information about sexually transmitted diseases and other similar information);
  - information related to alcohol and drug abuse and treatment;
  - information, records and data relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions; and
  - information, records and data relating to mental illness.
- The Company to redisclose information received pursuant to this Authorization as authorized by me in writing or as otherwise permitted by applicable law.
- The Company to request and obtain: consumer; investigative consumer; or motor vehicle reports.
- Any employer, business associate, financial institution, or government agency to give the Company any information or data that it may have about: occupations; avocations; driving record; finances; character; reputation; and aviation activities.

I understand that:

- Information, records and data that the Company receives pursuant to this Authorization will be used and maintained by the company as described in the Company's Privacy Notice, a copy of which was given to me.
- All or part of the information, records and data that the Company receives pursuant to this Authorization may be disclosed to MIB. Such information may also be disclosed to and used by: any reinsurer; any Company employee; or any affiliate or independent contractor who performs a business service for the Company on the insurance applied for or on existing insurance with the Company. Information may also be disclosed as otherwise required or permitted by applicable laws.
- Information related to alcohol and drug abuse that has been disclosed to the Company may be protected by Federal Regulations 42 CFR part 2. This information may be redisclosed as provided in this Authorization.
- Medical information, records and data disclosed may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, 45 CFR Parts 160-164. These rules set forth standards for the use, maintenance and disclosure of such information by health care providers and health plans. Once disclosed to the Company, this information may no longer be subject to those laws or regulations.
- Information obtained pursuant to this Authorization about me or such child(ren) may be used, to the extent permitted by law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- If underwriting determines that an investigative consumer report is needed, I will be contacted by the consumer reporting agency and interviewed in connection with its preparation.
- I am not required by law to sign this Authorization, but if I do not, the Company will not be able to underwrite my application for life insurance. In addition, health care provider(s) or health care plan(s) asked to release information pursuant to this Authorization can not condition treatment or payment for treatment or other benefits on my signing it.
- This Authorization will end 24 months from the date on this form or sooner if prescribed by law. I may revoke it at any time by writing to the Company and advising it that I have revoked this Authorization. Any action taken before the Company has received my revocation will be valid.
- I have a right to receive a copy of this form.

A photocopy of this form is as valid as the original form.

SIGNATURES:
(If a Proposed Insured is under age 18, the Parent or Guardian, (circle one) is to sign on line for such child.)

Proposed Insured #1 Hana Salamon Date 12/17/07

Print Name of Proposed Insured #1 Hana Salamon Date of Birth 1/12/1931

Proposed Insured #2 _____ Date _____

Print Name of Proposed Insured #2 _____ Date of Birth _____

Witness _____ Date _____

EAUTH-05-NY (05/05) eF

From: Berry, Benjamin [Benjamin.Berry@ic.fbi.gov]
Sent: Sunday, July 27, 2008 4:59 PM
To: Mostecak, Stephen
Subject: Re: Bank

Steve: Never heard of this "bank." Sounds fraudulent to me. A check with the New York State Banking Department would give you a definitive answer. Also, about six months ago I was transfered out of the bank fraud area. Hope this is helpful. Regards, Ben

From: Mostecak, Stephen
To: Berry, Benjamin
Sent: Fri Jul 25 10:13:31 2008
Subject: Bank

Hi Ben:

Came across your name on Dave Rosenzweig's External Crimes contact list. Quick question if I may, Sir. I'm investigating several suspect Stranger Owned Life Insurance policies in Brooklyn. An accountant of the insured indicates that this insured has a bank by the name of **Berkshire and Abrle** in Brooklyn, NY. I can't find this name anywhere? Might you have heard of it? I think it's just part of the scam.....Thanks.

Steve

Stephen J. Mostecak
Principal Investigator
AIG World Investigative Resources (AIGWIR)
Fraud Investigation Division
P.O. Box 372
West Nyack, NY 10994
Office: 845.398.0675; E-Fax: 1.866.667.8514
Cell: 917.862.2862
E/Mail: Stephen.Mostecak@AIG.com
F.I.D. Intranet Site: <http://aignetprod.aig.com/cffid>

AIG World Investigative Resources (AIGWIR)
P.O. Box 372
West Nyack, NY 10994
845.398.0675 – Voice
1.866.667.8514 – Easylink Fax
E-mail: stephen.mostecak@aig.com

* *

TO: Jim Bilello, MetLife
Fax: 908.655.9901
jbilello@metlife.com

FROM: STEPHEN J. MOSTECAK
Principal Investigator

DATE: May 30, 2008

RE: Hana Salamon

OF PAGES: 2
(Including this cover sheet)

* *

Hi Jim:

This request is regarding Hana Salamon, DOB: 1.12.1931.

Please consider this a Special Investigations Unit request in support of an internal fraud investigation to determine whether agents of American General Insurance Company may have committed insurance fraud against AIG involving a suspect IOLI/SOLI investigation.

American General has issued a life policy on Hana Salamon and I am aware that Ms. Salamon has applied for life coverage from MetLife.

I attach a copy of Hana Salamon's signed authorization. As such, may I request a copy of the policy application, and any financial disclosures, that Hana Salamon has provided MetLife, in furtherance of my investigation?

Thank you,

Stephen Mostecak
Principal Investigator
AIG World Investigative Resources
Fraud Investigation Division

American General Life Insurance Company, Houston, TX
The United States Life Insurance Company in the City of New York, New York, NY
AIG Life Insurance Company, Wilmington, DE

The above listed life insurance company ("Company") as selected on page one of this application is responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

Agreement, Authorization to Obtain and Disclose Information and Signatures

I, the Primary Proposed Insured and Owner signing below, agree that I have read the statements contained in this application and any attachments or they have been read to me. They are true and complete to the best of my knowledge and belief. I understand that this application: (1) will consist of Part A, Part B, and if applicable, related attachments including supplement(s) and addendum(s); and (2) shall be the basis for any policy and any rider(s) issued. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the policy is within its contestable period.

Except as may be provided in any Limited Temporary Life Insurance Agreement, I understand and agree that even if I paid a premium no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; and (2) the full first modal premium for the issued policy has been paid; and (3) there has been no change in the health of any Proposed Insured(s) that would change the answers to any questions in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that if all three conditions above are not met: (1) no insurance will begin in effect, and (2) the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

Limited Temporary Life Insurance Agreement ("LTLIA") – If I have received and accepted the LTLIA, I understand and agree that such insurance is available only on the life of the Primary Proposed Insured under the life policy (and the Other Proposed Insured under a joint and survivorship life policy, if applicable) and only if the following four conditions are met: (1) the full first modal premium is submitted with this application and paid; and (2) only "no" answers have been truthfully given to the Health and Age Questions in section 15; and (3) Part A and Part B of the application must be completed, signed and dated; and (4) all medical exam requirements must be satisfied. I understand and agree that such insurance is not available with any riders or any accident and/or health insurance.

I understand and agree that no agent is authorized to: accept risks or pass upon insurability; make or modify contracts; or waive any of the Company's rights or requirements.

I have received a copy or have been read the Notices to the Proposed Insured(s).

I give my consent to all of the entities listed below to give to the Company, its legal representatives, American General Life Companies LLC ("AGLC") (an affiliated service company), and affiliated insurers all information they have pertaining to: medical consultations; treatments; surgeries; hospital confinements for physical and/or mental conditions; use of drugs or alcohol; drug prescriptions; or any other information for me, my spouse or my minor children. Other information could include items such as: personal finances; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; court records; or foreign travel, etc. I give my consent for the information outlined above to be provided by: any physician or medical practitioner; any hospital, clinic or other health care facility; pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB).

I understand the information obtained will be used by the Company to determine: (1) eligibility for insurance; and (2) eligibility for benefits under an existing policy. Any information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; me; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent.

I, as well as any person authorized to act on my behalf, may, upon written request, obtain a copy of this consent. I understand this consent may be revoked at any time by sending a written request to the Company, Attn: Underwriting Department at P.O. Box 1931, Houston, TX 77251-1931. This consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize AGLC or affiliated insurers to obtain an investigative consumer report on me. I understand that I may: request to be interviewed for the report; and receive, upon written request, a copy of such report. ☐ Check if you wish to be interviewed.

IRS Certification: Under penalties of perjury, I certify: (1) that the number shown on this application is my correct Social Security or Tax ID number; and (2) that I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code; and (3) that I am a U.S. person (including a U.S. resident alien). The Internal Revenue Service does not require my consent to any provisions of this document other than the certifications required to avoid backup withholding. You must cross out item (2) if you are subject to backup withholding and cross out item (3) if you are not a U.S. person (including a U.S. resident alien).

Proposed Insured(s)/Owner Signature

Signed at (city, state) Lakewood NJ On (date) 12/13/07

Primary Proposed Insured X *(If under age 15, signature of parent or guardian)*

Other Proposed Insured X *(If under age 15, signature of parent or guardian)*

Owner *(If other than Primary Proposed Insured)* X

Agent(s) Signature(s)

I certify that the information supplied by the Primary Proposed Insured(s)/Owner has been truthfully and accurately recorded on the Part A application.

Writing Agent Name *(please print)* Yitzchak Halpert Writing Agent #

Writing Agent Signature X Countersigned *(Licensed resident agent if state required)*

DMV REQUEST FORM

(Must be filled out completely)

Date: July 21, 2008

Investigator: Stephen Mostecak Casetrack Number: 2008-0293

Insured: Salamon, Hana Policy Number: U10022254L

Claimant: Claim Number: N/A

Type of Policy:

Life

What would you like run:

Confirm and Verify Driver's License Number #658906493 DOB: 1/12/1931 or 1/21/1931

Do you need Insurance Info?

Negative

Reason for information:

Life Insurance Investigation

If you are in the field and would like a plate # run please provide color, make, model and location of the vehicle and date and time of location.

In the State of NJ you must have Driver's License #, you can not run by name.

**********RESULTS**********

*RECORD EXPANSION FOR: SALAMON,HANA
CLIENT ID#: 658906493
SALAMON,HANA DOB: 01/12/1931 SEX: F
4910 17 AVE 2J HEIGHT: 5-3 EYE COLOR: BLUE
BROOKLYN NY 11204 COUNTY: KING
MI #: S01411 09630 460888-31
ID ONLY EXPIRATION: 01/12/2013
*** END OF RECORD ***

[redacted]
Stephen Mostecak
Principal Investigator
Fraud Investigation Division
AIG World Investigative Resources
Northeast Region
P.O. Box 372
West Nyack, NY 10994
Phone: 845.398.0675
Cell: 917.862.2862
Fax:1.866.667.8514

August 7, 2008

Mr. Joel Katz, Trustee
750 Forest Avenue – Apt. 25D
Lakewood, NJ 08701

Re: Life Policy of Hana Salamon - # U10022254L – AIG American General – Issued 12/'07

Mr. Katz:

You, as well as Aaron Knopfler, are listed on the above policy of our insured, Hana Salamon. As part of our business practice, I am required to meet with you in person to discuss the Trust aspects of the policy set-up.

As such, kindly call me upon receipt of this letter at the above phone number so that we can schedule an appointment that is convenient for you.

Thank you very much and I anticipate an expedient response, sir.

Stephen Mostecak
Principal Investigator

Certified Mail – RRR and Regular USPS Delivery

DMV REQUEST FORM

(Must be filled out completely)

Date: July 21, 2008

Investigator: Stephen Mostecak **Casetrack Number: 2008-0293**

Insured: Salamon, Hana **Policy Number: U10022254L**

Claimant: **Claim Number: N/A**

Type of Policy:
Life

What would you like run:
Confirm and Verify Driver's License Number #658906493 DOB: 1/12/1931 or 1/21/1931

Do you need Insurance Info?
Negative

Reason for information:
Life Insurance Investigation

If you are in the field and would like a plate # run please provide color, make, model and location of the vehicle and date and time of location.

In the State of NJ you must have Driver's License #, you can not run by name.

**********RESULTS**********

*RECORD EXPANSION FOR: SALAMON,HANA

CLIENT ID#: 658906493

SALAMON,HANA
DOB: 01/12/1931 SEX: F

4910 17 AVE 2J
HEIGHT: 5-3 EYE COLOR: BLUE

BROOKLYN NY 11204
COUNTY: KING

MI #: S01411 09630 460888-31

ID ONLY
EXPIRATION: 01/12/2013

*** END OF RECORD ***

PART I Check the appropriate company. Office Use Only: 1

Application for Individual and Multi-Life Life Insurance

- ☐ Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166
- ☐ First MetLife Investors Insurance Company, 200 Park Avenue New York, NY 10166
- ☐ New England Life Insurance Company, 501 Boylston Street, Boston, MA 02116-3700

The Company indicated above is referred to as "the Company".

SECTION 1 Proposed Insured(s)

*If less than 3 years, add prior residence address in Additional Information Section, Page 13.

NOTE: P.O. Box numbers **CANNOT** be accepted for street addresses.

1. PROPOSED INSURED #1

Name Hana Salamon
Street 4916 17th Ave Suite 2J
City Brooklyn State NY Zip 11204
Years at this address* 15 SSN/Tax ID 319-82-9296
Home Phone Number (718) 851-9250 Best time to call: From 10:00 To 05:00
Work Phone Number (718) 928-5462 ☒ Daytime ☐ Evening
Cell Phone Number ( ) Best number to call: ☒ Home ☐ Work ☐ Cell
Driver's License Number State
License Issue Date License Expiration Date
Marital Status ☐ Single ☒ Married ☐ Separated ☐ Divorced ☐ Widowed
Date of Birth 01/12/31 State/Country of Birth Romania
Sex ☐ Male ☒ Female Net Worth $ 10,000,000
Annual Earned Income $ 100,000 Annual Unearned Income $ 50,000
Employer's Name SELF EMPLOYED
Street 4916 17th Ave Suite 2J
City Brooklyn State NY Zip 11204
Position/Title/Duties Artist Length of Employment 48

2. PROPOSED INSURED #2

Life 2, Spouse, Designated Life, Person to be covered under Applicant's Waiver of Premium Benefit

If address is same as Proposed Insured #1, write "SAME".

ADDITIONAL INSUREDS: See Supplemental Forms Package.

Relationship to Proposed Insured #1
Name
Street
City State Zip
Years at this address* SSN/Tax ID
Home Phone Number ( )
Work Phone Number ( ) Best time to call:
Cell Phone Number ( ) ☐ Daytime ☐ Evening
Driver's License Number Best number to call ☐ Home ☐ Work ☐ Cell
Issue Date State
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Expiration Date
Date of Birth State/Country of Birth
Sex ☐ Male ☐ Female Net Worth $
Annual Earned Income $ Annual Unearned Income $
Employer's Name
Street
City State Zip
Position/Title/Duties Length of Employment

ENB-7-05-NY (09/06) eF

2

If more space is needed, please use the Additional Information Section, Page 13.

SECTION 1 Proposed Insured(s) *(continued)*

3. DEPENDENT SPOUSE or MINOR

A. Are any persons to be insured a dependent spouse? ☐ YES ☑ NO

IF YES, please provide.

Amount of **existing** insurance on spouse of Proposed Insured $_____

Amount of insurance **applied for** on spouse of Proposed Insured $_____

B. 1. Are any persons to be insured a dependent minor? ☐ YES ☑ NO

IF YES, please provide:

Amount of **existing** insurance on father/guardian $_____

Amount of insurance **applied for** on father/guardian $_____

Amount of **existing** insurance on mother/guardian $_____

Amount of insurance **applied for** on mother/guardian $_____

2. Are all siblings of this dependent minor equally insured? ☐ YES ☑ NO

IF NO, please provide details:

_____

SECTION 2 Existing or Applied For Insurance

IF YES
Some states require the completion of an additional form. See instructions on the cover of the Replacement Forms Package.

1. EXISTING or APPLIED FOR INSURANCE

A. Do any of the Proposed Insureds or Owners have any existing or applied for life insurance (L) or annuity (A) contracts with this or any other company?

Proposed Insured ☐ YES ☑ NO

Owner ☐ YES ☐ NO

IF YES, provide details on **Proposed Insured only:**

Proposed Insured (#1, #2, other)	Company	Type (L A)	Amount of Insurance	Year of Issue	Accidental Death Amount	Existing or Applied for
						☐E ☐A
						☐E ☐A
						☐E ☐A
						☐E ☐A
						☐E ☐A

B. Do any of the Proposed Insureds have any application for disability insurance (D) or critical illness insurance (C) or long term care insurance (LTC) applied for or planned with **THIS** Company or its affiliates? ☐ YES ☑ NO

IF YES, provide. Proposed Insured(#1, #2, other)_____ Type (D,C,LTC) _____

Applicable replacement and 1035 exchange forms can be found in Replacement Forms Package.

2. REPLACEMENT

A. In connection with this application, has there been, or will there be with this or any other company any: surrender transaction; loan; withdrawal; lapse, reduction or redirection of premium/consideration; or change transaction (except conversions) involving an annuity or other life insurance? ☐ YES ☑ NO

IF YES, complete Replacement Questionnaire and Disclosure **AND** any other state required replacement forms.

B. Is this an exchange under Internal Revenue code section 1035? ☐ YES ☑ NO

IF YES, complete the 1035 Exchange Authorization **for each affected policy.**

If more space is needed, please use the Additional Information Section, Page 13. 3

SECTION 3 Owner

IDENTITY of PRIMARY OWNER (Check one.)
- ☐ Proposed Insured #1 Complete Question 1 ONLY.
- ☐ Proposed Insured #2 Complete Question 1 ONLY.
- ☐ Other Person Complete Questions 1 and 2.
- ☑ Entity Complete Question 3 ONLY.

If U.S. Driver's License already provided, no further information is required.

1. OWNER IDENTIFICATION
- ☐ U.S. Driver's License already provided on page 1 (Proposed Insured)
- ☐ U.S. Driver's License ☐ Green Card ☐ Passport ☑ Other ID Card
- Issuer of ID New York State ID Issue Date 06/07/07
- ID Reference Number 658906493 ID Expiration Date 01/12/13

NOTE: P.O. Box numbers **CANNOT** be accepted for street addresses.

2. OWNER other than PROPOSED INSURED(S)
- Name
- Street
- City State Zip
- Phone Number ( )
- Citizenship Country of Permanent Residence
- Date of Birth SSN/Tax ID
- Relationship to Proposed Insured(s)
- Employer's Name
- Street
- City State Zip
- Position/Title/Duties Length of Employment
- ☐ Check if you wish ownership to revert to Insured upon Owner and Contingent Owner's death.

IF CUSTODIAN is acting on behalf of a minor under UTMA/UGMA, please complete Additional Owner Form in Supplemental Forms package.

3. ENTITY/TRUST AS OWNER

Entity/Trust Type: ☐ C Corporation ☐ S Corporation ☐ LLC ☐ Partnership ☐ Sole Proprietorship ☑ Trust

IF TRUST Complete Trust Certification form in Supplemental Forms Package.
- Tax ID Number Date of Trust
- Name of Entity/Trust Trust to be established
- Name of Trustee(s)
- Street
- City State Zip

IF BUSINESS Complete Business Supplement form in Supplemental Forms Package.
- Proposed Insured(s) Relationship to Entity
- Nature of Business Business Phone
- Is entity publicly traded? ☐ YES ☐ NO
- **IF NO,** please supply one of the following documents: *(Indicate which one you are supplying.)*
  - ☐ Articles of Incorporation/Government Issued Business License
  - ☐ LLC Operating Agreement
  - ☐ Partnership Agreement
  - ☐ Government Issued Certificate of Good Standing

If more space is needed, please use the Additional Information Section, Page 13.

SECTION 4 Beneficiary(ies)

NOTE: Federal law states if you leave someone with special needs any assets over $2,000, they may lose eligibility for most government benefits.

Contingent Beneficiaries ONLY

☐ Check here if you want any and all living and future natural or adopted children of Proposed Insured #1 to be included as Contingent Beneficiaries. Name any living children as beneficiaries below.

☐ **Check here AND DO NOT COMPLETE if Primary Beneficiary is same as Trust or Entity Owner.**

If there is a court appointed legal Guardian for Beneficiary, provide name and address in Additional Information Section, Page 13.

☐ **PRIMARY**

Name _____

Street _____

City _____ State _____ Zip _____

Date of Birth _____ SSN/Tax ID _____

Relationship to Proposed Insured(s) _____

Percent of Proceeds _____ (Multiple Beneficiaries will receive an equal percentage of proceeds unless otherwise instructed.)

☐ **PRIMARY** ☐ **CONTINGENT**

Name _____

Street _____

City _____ State _____ Zip _____

Date of Birth _____ SSN/Tax ID _____

Relationship to Proposed Insured(s) _____

Percent of Proceeds _____ (Multiple Beneficiaries will receive an equal percentage of proceeds unless otherwise instructed.)

☐ **PRIMARY** ☐ **CONTINGENT**

Name _____

Street _____

City _____ State _____ Zip _____

Date of Birth _____ SSN/Tax ID _____

Relationship to Proposed Insured(s) _____

Percent of Proceeds _____ (Multiple Beneficiaries will receive an equal percentage of proceeds unless otherwise instructed.)

SECTION 5 Custodian acting for Minor Beneficiary(ies)

Custodian's name _____

as custodian for _____

under the _____ Uniform Transfers [or Gifts] to Minors Act

Street _____

City _____ State _____ Zip _____

Relationship to Minor(s) _____

If more space is needed, please use the Additional Information Section, Page 13. 5

SECTION 6 Information Regarding Insurance Applied for

1. PRODUCT & FACE AMOUNT

Product Name Guaranteed Advantage ML

Face Amount $ 10,000,000 *(Complete Personal Financial Supplement if $1,000,000 or more.)*

☐ Group Conversion*

Optional Benefits and Riders:

☐ Guaranteed Survivor Plus Purchase Options (GSPO+)*
Option Period(s): _____ $ _____

☐ Guaranteed Survivor Income Benefit (GSIB)

☐ Term Rider *Specify:* _____ $ _____

☐ Life Guaranteed Purchase Option (LGPO)

☐ Acceleration of Death Benefit Rider (ADBR)*

☐ Enricher Options (PAIR/VABR)* *Specify* _____ $ _____

☐ Long Term Care Guaranteed Purchase Option (LTC-GPO)

☐ Disability Waiver (DW) *Specify:* _____ $ _____

☐ Other _____

Special Requests/Other:

☐ Save Age ☐ Specific Policy Date _____

☐ Other _____

Check here if ☐ alternate **OR** ☐ additional policy is requested and provide full details below. Include **SIGNED & DATED** illustration for each policy requested.

*Complete these forms, if applicable:
- ADBR
- Enricher/Equity Additions
- Group Conversion
- GSPO+

These forms can be found in the Supplemental Forms Package.

2. ADDITIONAL INFORMATION for WHOLE LIFE PRODUCTS

Do you request automatic payment of premium in default by Policy Loan *(for traditional plans)*, if available? ☐ YES ☐ NO

Dividend Options:

☐ Paid-up Additions ☐ VAI Equity Additions* ☐ Premium Reduction

☐ Cash ☐ Accumulations/DWI

☐ Other _____

3. ADDITIONAL INFORMATION for UNIVERSAL LIFE/VARIABLE LIFE PRODUCTS

For Variable Life, also complete Variable Life Supplement.

Planned Premium Amount: Year 1 $ 456,873 Excess/Lump Sum $ 0

Duration of premium payments 23 years

Planned annual unscheduled payment *(if applicable)*: $ 0

Renewal Premium *(if applicable)*: $ 456,873

Death Benefit Option/Contract Type Option One

Definition of Life Insurance Test: ☐ Guideline Premium Test ☐ Cash Value Accumulation Test *(if available under policy applied for)*

Guaranteed to age. *(VUL only)* ☐ 65 ☐ 75 ☐ 85 ☐ 5 years ☐ Other _____

4. ADDITIONAL INFORMATION for QUALIFIED PLANS

Qualified/Non-Qualified Plan number _____

If more space is needed, please use the Additional Information Section, Page 13.

SECTION 7 Payment Information

If **Monthly Electronic Payment** is chosen, complete Electronic Payment Account Agreement

1. PAYMENT MODE (Check one)

Direct Bill: ☒ Annual ☐ Semi-Annual ☐ Quarterly

Electronic Payment: ☐ Monthly

Special Account: ☐ Government Allotment ☐ Salary Deduction

Additional Details: _____

2. SOURCE of CURRENT and FUTURE PAYMENTS (Check all that apply)

☐ Earned Income ☐ Mutual Fund/Brokerage Account ☐ Money Market Fund ☒ Savings

☐ Use of Values in another Life Insurance/Annuity Contract ☐ Certificate of Deposit

☐ Loans ☐ Other _____

NOTE:
It is Company policy to not accept cash, traveler's checks, or money orders as a form of payment for Variable Life Products.

3. PAYMENT

Amount collected with application $ _____
(Must equal at least one monthly premium)

Premium Payor:

☐ Proposed Insured #1 ☐ Proposed Insured #2 ☒ Primary Owner

☐ Other

Name _____

Relationship to Proposed Insured(s) and Owner _____

Reason this person is the Payor _____

4. BILLING ADDRESS INFORMATION

☐ Proposed Insured #1 Address ☐ Proposed Insured #2 Address

☒ Primary Owner's Address

☐ Other Premium Payor's/Alternate Billing Address *(provide details here)*

Street _____

City _____ State _____ Zip _____

☐ Special Arrangements

_____

_____

_____

E-Mail Addresses
(optional)

Proposed Insured #1 _____

Proposed Insured #2 _____

Primary Owner _____

Joint/Contingent Owner _____

If more space is needed, please use the Additional Information Section, Page 13. 7

SECTION 8 General Risk Questions

The following questions are to be answered for **ALL** persons to be insured, including those covered by any riders applied for.

1. Within the past three years has **ANY** person to be insured flown in a plane other than as a passenger on a scheduled airline or have plans for such activity within the next year? ☐ YES ☑ NO

IF YES, complete a separate Aviation Supplement for each applicable Proposed Insured.

2. Within the past three years has **ANY** person to be insured participated in ~~or intend to participate in any of the following~~
Underwater sports - (SCUBA diving, skin diving, or similar activities);
Sky sports - (skydiving, hang gliding, parachuting, ballooning or similar activities);
Racing sports - (motorcycle, auto, motor boat or similar activities);
Rock or mountain climbing or similar activities;
Bungee jumping or similar activities? ☐ YES ☑ NO

IF YES, complete a separate Avocation Supplement for each applicable Proposed Insured.

If you need more space, please use the Additional Information Section, Page 13

3. Within the **next two years** does **ANY** person to be insured **intend to travel** or **reside** outside the U.S. or Canada? ☐ YES ☑ NO

IF YES, for each occurence, please provide Proposed Insured, duration, country and purpose.

_____

_____

_____

4. CITIZENSHIP/RESIDENCY

A. Are all persons to be insured **U.S. Citizens?** ☑ YES ☐ NO

IF NO, please provide details:

Proposed Insured(s) _____ Country of Citizenship _____

Visa Type/ID _____ Visa Number _____

Expiration Date _____ Length of Time in U.S. _____

☐ Check here if currently applying for a Social Security number.

B. Are all persons to be insured **permanent residents** of the United States? ☑ YES ☐ NO

IF NO, please provide details:

Proposed Insured(s) _____

Country of Residence _____

8 **If more space is needed, please use the Additional Information Section, Page 13.**

SECTION 8 General Risk Questions *(continued)*

The following questions are to be answered for **ALL** persons to be insured, including those covered by any riders applied for.

5. In the last five years, has **ANY** person to be insured used tobacco products (e.g., cigarettes; cigars; pipes; smokeless tobacco; chew; etc.) or nicotine substitutes (e.g., patch, gum)? ☐ **YES** ☑ **NO**

IF YES, please provide details:

Proposed Insured(s) _____ Date Last Used _____

Type _____

Amount/Frequency _____

If you need more space, please use the Additional Information Section, Page 13.

6. Has **ANY** person to be insured: **EVER** had a driver's license suspended or revoked, **EVER** been convicted of DUI or DWI; or had, in the last five years, any moving violations? ☐ **YES** ☑ **NO**

IF YES, please provide Proposed Insured, date and violation.

Proposed Insured(s) _____

Details: _____

7. Has any person to be insured **EVER** had an application for life, disability income or health insurance declined, postponed, rated or modified or required an extra premium? ☐ **YES** ☑ **NO**

IF YES, please provide details:

Proposed Insured(s) _____

Details: _____

8. Are all persons to be insured* actively at work; or a homemaker performing regular household duties; or a student attending school regularly? ☑ **YES** ☐ **NO**

IF NO, please provide details:

Proposed Insured(s) _____

Details: _____

Please answer these questions **only if requesting the Long Term Care Guaranteed Purchase Option Rider.**

9. LONG TERM CARE GUARANTEED PURCHASE OPTION RIDER

A. Does any person to be insured under this rider currently use any mechanical equipment such as: a walker; a wheelchair; long leg braces; or crutches? ☐ **YES** ☐ **NO**

IF YES, please note which and the reason.

Proposed Insured(s) _____

B. Does any person to be insured under this rider need any assistance or supervision with any of the following activities: bathing; dressing; walking; moving in/out of a chair or bed; toileting; continence; or taking medication? ☐ **YES** ☐ **NO**

Proposed Insured(s) _____

PART II If more space is needed, please use the Additional Information Section, Page 13. 9

SECTION 1 Physician Information

PLEASE NOTE: If FULL PARAMEDICAL exam is required, completion of Medical questions is **OPTIONAL** but will expedite your application

1. PHYSICIAN

Please provide name of doctor, practitioner, or health care facility who can provide the most complete and up to date information concerning the present health of the Proposed Insured(s).

Physician Information for Proposed Insured #1

☐ Check here if no doctor, practitioner or health care facility is known.

Physician Name Slomowits Joseph Md Phone Number (718) 851-8400

Name of Practice/Clinic _____ Fax Number (____) _____

Street 5023 15 Ave

City Brooklyn State NY Zip 11219

Date Last Consulted _____ Reason _____

Findings, treatment given, medication prescribed. If None, check here ☐.

Physician Information ☐ **Proposed Insured #1** ☐ **Proposed Insured #2**

☐ Check here if no doctor, practitioner or health care facility is known.

Physician Name _____ Phone Number (____) _____

Name of Practice/Clinic _____ Fax Number (____) _____

Street _____

City _____ State ____ Zip _____

Date Last Consulted _____ Reason _____

Findings, treatment given, medication prescribed. If None, check here ☐.

SECTION 2 Medical Questions

1. HEIGHT/WEIGHT

Proposed Insured #1 Height _____ Weight _____

Proposed Insured #2 Height _____ Weight _____

Has any Proposed Insured experienced a change in weight (greater than 10 pounds) in the past 12 months? ☐ **YES** ☐ **NO**

IF YES, specify:

Proposed Insured #1 Pounds lost _____ Pounds gained _____

Proposed Insured #2 Pounds lost _____ Pounds gained _____

Reason _____

If more space is needed, please use the Additional Information Section, Page 13.

SECTION 2 Medical Questions

(continued)

PLEASE NOTE: If FULL PARAMEDICAL exam is required, completion of Medical questions is **OPTIONAL** but will expedite your application.

2. Has a parent (P) or sibling (S) of any person to be insured ever had: heart disease; coronary artery disease; high blood pressure; diabetes; or mental illness? ☐ **YES** ☐ **NO**

IF YES, indicate below:

Proposed Insured (#1, #2)	Relationship to Proposed Insured	Age if Living	Age at Death	State of Health, Specific Conditions, Cause of Death
	☐ P ☐ S			
	☐ P ☐ S			
	☐ P ☐ S			
	☐ P ☐ S			

3. Has **ANY** person to be insured **EVER** received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that he/she had:

	Proposed Insured #1		Proposed Insured #2		Other Proposed Insured	
	YES	NO	YES	NO	YES	NO
A. High blood pressure; chest pain; heart attack, or any other disease or disorder of the heart or circulatory system?	☐	☐	☐	☐	☐	☐
B. Asthma; bronchitis; emphysema; sleep apnea; shortness of breath; or any other disease or disorder of the lungs or respiratory system?	☐	☐	☐	☐	☐	☐
C. Seizures; stroke; paralysis; Alzheimer's disease; multiple sclerosis; memory loss; Parkinson's disease; progressive neurological disorder; headaches; or any other disease or disorder of the brain or nervous system?	☐	☐	☐	☐	☐	☐

Details: If you **answered YES** to any of the above questions, please provide details here.

Question Number	Proposed Insured Name	Name of Physician Address if not already provided	Date/Duration of Illness	Diagnosis/Severity Medications/Treatment

If more space is needed, please use the Additional Information Section, Page 13. 11

SECTION 2 Medical Questions
(continued)

PLEASE NOTE: If FULL PARAMEDICAL exam is required, completion of Medical questions is **OPTIONAL** but will expedite your application

3. Has **ANY** person to be insured **EVER** received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that he/she had:

	Proposed Insured #1		Proposed Insured #2		Other Proposed Insured	
	YES	NO	YES	NO	YES	NO
D. Ulcers; colitis; hepatitis, cirrhosis; or any other disease or disorder of the liver; gallbladder, stomach, or intestines?	☐	☐	☐	☐	☐	☐
E. Any disease or disorder of: the kidney; bladder; or prostate; or blood, protein or pus in the urine?	☐	☐	☐	☐	☐	☐
F. Diabetes; thyroid disorder; or any other endocrine problem(s)?	☐	☐	☐	☐	☐	☐
G. Arthritis; gout; or disorder of the muscles, bones or joints?	☐	☐	☐	☐	☐	☐
H. Cancer; tumor; polyp; cyst or any skin disease or disorder?	☐	☐	☐	☐	☐	☐
I. Anemia; leukemia; or any other disorder of the blood or lymph glands?	☐	☐	☐	☐	☐	☐
J. Depression; stress; anxiety; or any other psychological or emotional disorder or symptoms?	☐	☐	☐	☐	☐	☐
K. Any disease or disorder of the eyes, ears, nose, or throat?	☐	☐	☐	☐	☐	☐

Details: If you **answered YES** to any of the above questions, please provide details here.

Question Number	Proposed Insured Name	Name of Physician Address if not already provided	Date/Duration of Illness	Diagnosis/Severity Medications/Treatment

If more space is needed, please use the Additional Information Section, Page 13.

SECTION 2 Medical Questions
(continued)

PLEASE NOTE: If FULL PARAMEDICAL exam is required, completion of Medical questions is **OPTIONAL** but will expedite your application.

4. Has **ANY** person to be insured:

	Proposed Insured #1 YES	Proposed Insured #1 NO	Proposed Insured #2 YES	Proposed Insured #2 NO	Other Proposed Insured YES	Other Proposed Insured NO
A. Currently, or within the past six months, been under observation or received treatment or taken any medication? (Including over-the-counter medications, vitamins, herbal supplements, etc.)	☐	☐	☐	☐	☐	☐
B. For the next six months, scheduled any doctor's visits, medical care, or surgery?	☐	☐	☐	☐	☐	☐
C. During the past five years, had a: checkup; electrocardiogram; chest x-ray; or medical test?	☐	☐	☐	☐	☐	☐
D. During the past five years, had any illness, injury or health condition not revealed above; or have been recommended to have any: hospitalization; surgery; medical test; or medication?	☐	☐	☐	☐	☐	☐
E. EVER been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐	☐	☐	☐	☐
F. EVER used heroin, cocaine, barbituates, or other drugs, except as prescribed by a physician or other licensed practitioner?	☐	☐	☐	☐	☐	☐
G. EVER received treatment from a physician or counselor regarding the use of alcohol, or the use of drugs, except for medicinal purposes; or received treatment or advice from an organization that assists those who have an alcohol or drug problem?	☐	☐	☐	☐	☐	☐

Details: If you **answered YES** to any of the above questions, please provide details here.

Question Number	Proposed Insured Name	Name of Physician Address if not already provided	Date/Duration of Illness	Diagnosis/Severity Medications/Treatment

[redacted]

Additional Information

Use this page for any additional information.
Attach a separate sheet if necessary.

Certification/ Agreement/ Disclosure

Certification Regarding Sales Illustration Agent must check the appropriate statement below.

☑ Agent certifies that a signed illustration is **not required** by law or the policy applied for is not illustrated in this state.

☐ ~~An illustration was signed and matches the policy applied for. It is included with this application.~~

☐ An illustration was shown or provided but is **different from the policy applied for.** An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

☑ **No illustration conforming to the policy** as applied for was shown or provided prior to or at the time of this application. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

☐ If illustration was **only shown on a computer screen,** check and complete details below.

An illustration was displayed on a computer screen. The displayed illustration **matches the policy applied for** but no printed copy of the illustration was provided. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery. The illustration on the screen included the following personal and policy information:

1. Gender (as illustrated) ☐ M ☐ F ☐ Unisex Age _____
2. Rating class (e.g. standard, smoker) ☐ Preferred ☐ Standard ☐ Non-smoker ☐ Smoker
   ☐ Other _____
3. Type of policy (e.g. L-98, Whole Life) _____
4. Initial Death Benefit $ _____ Death Benefit Option _____
5. Guaranteed Minimum Death Benefit ☐ age 55 ☐ age 65 ☐ age 75 ☐ age 85 ☐ 5 years
6. Dividend Option _____
7. Riders _____ $ _____
   _____ $ _____
   _____ $ _____

Agreement/Disclosure

I have read this application for life insurance including any amendments and supplements and to the best of my knowledge and belief, all statements are true and complete. I also agree that:

- My statements in this application and any amendment(s), paramedical/medical exam and supplement(s) are the basis of any policy issued.
- This application and any amendment(s); paramedical/medical exam; and supplement(s) to this application, will be attached to and become part of the new policy.
- No information will be deemed to have been given to the Company unless it is stated in this application and paramedical/medical exam, and any supplement(s).
- Only the Company's President, Secretary or Vice-President may: (a) make or change any contract of insurance; (b) make a binding promise about insurance; or (c) change or waive any term of an application, receipt, or policy.
- Except as stated in the Temporary Insurance Agreement and Receipt, no insurance will take effect until a policy is delivered to the Owner and the full first premium due is paid. It will only take effect at the time it is delivered if: (a) the condition of health of each person to be insured is the same as stated in the application; and (b) no person to be insured has received any medical advice or treatment from a medical practitioner since the date of the application.

Certification/ Agreement/ Disclosure

(continued)

- I understand that paying my insurance premiums more frequently than annually may result in a higher yearly out-of-pocket cost or different cash values.
- **If I intend to replace existing insurance or annuities, I have so indicated in Section 2, Question 2 of this application.**
- **I have received the Company's Consumer Privacy Notice and, as required, the Life Insurance Buyer's Guide.**
- **If I was required to sign an HIV Informed Consent Authorization, I have received a copy of that Authorization.**
- I understand that receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. A discount is associated with the acceleration and an administrative charge will be required upon exercise of the benefit.

Taxpayer Identification Number Certification

Under penalties of perjury, I, the Owner, certify that:

The number shown in this application is my correct taxpayer identification number, and I am not subject to backup withholding because:

(a) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, **OR**

(b) the IRS has notified me that I am not subject to backup withholding. *(If you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return, you must cross out and initial this item.)*

I am a U.S. citizen or a U.S. resident alien for tax purposes.

(If you are not a U.S. citizen or a U.S. resident alien for tax purposes, please cross out this certification and complete form W-8BEN).

Please note: The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

SIGNATURES:

If not witnessing all signatures, Witness should sign next to the signature being witnessed.

Signed at City, State Brooklyn NY Date 12/17/07

Proposed Insured #1 Hava Solomon
(age 15 or over)

Signed at City, State _____ Date _____

Proposed Insured #2 _____
(age 15 or over)

Signed at City, State _____ Date _____

Owner _____
(If other than Proposed Insured)
(If age 15 or over) If the Owner is a firm or corporation, include Officer's title with signature.

Signed at City, State _____ Date _____

Parent or Guardian _____
(If Owner or Proposed Insured(s) is/are under 18, sign here if not signed above.)

Signed at City, State Brooklyn NY Date 12/17/07

Witness to Signatures _____
(Licensed Agent/Producer)

Please print Agent/Producer name Mayer Kramarsky

ENB-7-05-NY (09/06) eF

J

Check the appropriate company.

Personal Financial Supplement

Proposed Insured: Hana Salomon

- ☐ Metropolitan Life Insurance Company
- ☐ New England Life Insurance Company
- ☐ MetLife Investors Insurance Company
- ☐ MetLife Investors USA Insurance Company
- ☐ General American Life Insurance Company
- ☐ Metropolitan Tower Life Insurance Company

The Company indicated above is referred to as "the Company".

To be completed when the amount of coverage is $1,000,000 and over.

INCOME

Annual Earned Income

Salary or Draw	$ 100,000.00	
Bonus/Commissions	$	
Other Earnings	$	Source
Total Earned Income	$ 100,000.00	
Spouse's Income	$	

Annual Unearned Income

Dividends/Interest	$ 50,000.00	
Net Rentals	$	
Other Unearned	$	Source
Total Unearned Income	$ 50,000.00	

ASSETS & LIABILITIES

Assets		Liabilities	
Cash	$	Mortgages	$
Real Estate	$	Personal Loans	$
Business Equity	$	Other	$
Stocks/Bonds	$		
Other Assets	$ 10,000,000.00		
Total Assets	$ 10,000,000.00	**Total Liabilities**	$

Total Assets	$	10,000,000.00
Total Liabilities	-$	0.00
Net Worth:	=$	10,000,000.00

EFIN-05 (05/05) FF

PART I Check the appropriate company. Office Use Only: 1

Application for Individual and Multi-Life Life Insurance

- ☐ Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166
- ☐ First MetLife Investors Insurance Company, 200 Park Avenue, New York, NY 10166
- ☐ New England Life Insurance Company, 501 Boylston Street, Boston, MA 02116-3700

The Company indicated above is referred to as "the Company".

SECTION 1 Proposed Insured(s)

*If less than 3 years, add prior residence address in Additional Information Section, Page 13.

1. PROPOSED INSURED #1

Name Hana Salamon
Street 4910 17th Ave Suite 2J
City Brooklyn State NY Zip 11204
Years at this address* 15 SSN/Tax ID 319-82-9296
Home Phone Number (718) 851-9250 Best time to call: FROM 10:00
Work Phone Number (718) 926-5442 ☒ Daytime ☐ Evening TO 05:00
Cell Phone Number ( ) Best number to call: ☒ Home ☐ Work ☐ Cell
Driver's License Number State
License Issue Date License Expiration Date
Marital Status ☐ Single ☒ Married ☐ Separated ☐ Divorced ☐ Widowed
Date of Birth 01/12/31 State/Country of Birth Romania
Sex ☐ Male ☒ Female Net Worth $ 10,000,000
Annual Earned Income $ 100,000 Annual Unearned Income $ 50,000
Employer's Name SELF EMPLOYED
Street 4910 17th Ave Suite 2J
City Brooklyn State NY Zip 11204
Position/Title/Duties Artist Length of Employment 40

NOTE: P.O. Box numbers **CANNOT** be accepted for street addresses.

2. PROPOSED INSURED #2

Life 2, Spouse, Designated Life, Person to be covered under Applicant's Waiver of Premium Benefit

Relationship to Proposed Insured #1
Name
Street
City State Zip
Years at this address* SSN/Tax ID
Home Phone Number ( )
Work Phone Number ( ) Best time to call: ☐ Daytime ☐ Evening
Cell Phone Number ( ) Best number to call ☐ Home ☐ Work ☐ Cell
Driver's License Number State
Issue Date Expiration Date
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Date of Birth State/Country of Birth
Sex ☐ Male ☐ Female Net Worth $
Annual Earned Income $ Annual Unearned Income $
Employer's Name
Street
City State Zip
Position/Title/Duties Length of Employment

If address is same as Proposed Insured #1, write "SAME".

ADDITIONAL INSUREDS: See Supplemental Forms Package.

ENB-7-05-NY (09/06) eF

If more space is needed, please use the Additional Information Section, Page 13.

SECTION 1 Proposed Insured(s)
(continued)

3. DEPENDENT SPOUSE or MINOR

A. Are any persons to be insured a dependent spouse? ☐ YES ☑ NO

IF YES, please provide.

Amount of **existing** insurance on spouse of Proposed Insured $_____

Amount of insurance **applied for** on spouse of Proposed Insured $_____

B. 1. Are any persons to be insured a dependent minor? ☐ YES ☑ NO

IF YES, please provide:

Amount of **existing** insurance on father/guardian $_____

Amount of insurance **applied for** on father/guardian $_____

Amount of **existing** insurance on mother/guardian $_____

Amount of insurance **applied for** on mother/guardian $_____

2. Are all siblings of this dependent minor equally insured? ☐ YES ☑ NO

IF NO, please provide details:

_____

SECTION 2 Existing or Applied For Insurance

IF YES
Some states require the completion of an additional form. See instructions on the cover of the Replacement Forms Package.

1. EXISTING or APPLIED FOR INSURANCE

A. Do any of the Proposed Insureds or Owners have any exisitng or applied for life insurance (L) or annuity (A) contracts with this or any other company?

Proposed Insured ☐ YES ☑ NO

Owner ☐ YES ☐ NO

IF YES, provide details on **Proposed Insured only:**

Proposed Insured (#1, #2, other)	Company	Type (L, A)	Amount of Insurance	Year of Issue	Accidental Death Amount	Existing or Applied for
						☐ E ☐ A
						☐ E ☐ A
						☐ E ☐ A
						☐ E ☐ A
						☐ E ☐ A

B. Do any of the Proposed Insureds have any application for disability insurance (D) or critical illness insurance (C) or long term care insurance (LTC) applied for or planned with **THIS** Company or its affiliates? ☐ YES ☑ NO

IF YES, provide. Proposed Insured(#1, #2, other) _____ Type (D,C,LTC) _____

Applicable replacement and 1035 exchange forms can be found in Replacement Forms Package.

2. REPLACEMENT

A. In connection with this application, has there been, or will there be with this or any other company any: surrender transaction; loan; withdrawal; lapse, reduction or redirection of premium/consideration; or change transaction (except conversions) involving an annuity or other life insurance? ☐ YES ☑ NO

IF YES, complete Replacement Questionnaire and Disclosure **AND** any other state required replacement forms.

B. Is this an exchange under Internal Revenue code section 1035? ☐ YES ☑ NO

IF YES, complete the 1035 Exchange Authorization **for each affected policy.**

If more space is needed, please use the Additional Information Section, Page 13. 3

SECTION 3 Owner

IDENTITY of PRIMARY OWNER (Check one.)
- ☐ Proposed Insured #1 **Complete Question 1 ONLY.**
- ☐ Proposed Insured #2 **Complete Question 1 ONLY.**
- ☐ Other Person **Complete Questions 1 and 2.**
- ☑ Entity **Complete Question 3 ONLY.**

1. OWNER IDENTIFICATION

If U.S. Driver's License already provided, no further information is required.

- ☐ U.S. Driver's License already provided on page 1 (Proposed Insured)
- ☐ U.S. Driver's License ☐ Green Card ☐ Passport ☑ Other ID Card
- Issuer of ID New York State — ID Issue Date 06/07/07
- ID Reference Number 658906493 — ID Expiration Date 01/12/13

2. OWNER other than PROPOSED INSURED(S)

NOTE: P.O. Box numbers **CANNOT** be accepted for street addresses.

IF CUSTODIAN is acting on behalf of a minor under UTMA/UGMA, please complete Additional Owner Form in Supplemental Forms package.

- Name
- Street
- City — State — Zip
- Phone Number ( )
- Citizenship — Country of Permanent Residence
- Date of Birth — SSN/Tax ID
- Relationship to Proposed Insured(s)
- Employer's Name
- Street
- City — State — Zip
- Position/Title/Duties — Length of Employment
- ☐ Check if you wish ownership to revert to Insured upon Owner and Contingent Owner's death.

3. ENTITY/TRUST AS OWNER

Entity/Trust Type: ☐ C Corporation ☐ S Corporation ☐ LLC ☐ Partnership ☐ Sole Proprietorship ☑ Trust

IF TRUST Complete Trust Certification form in Supplemental Forms Package.

- Tax ID Number — Date of Trust
- Name of Entity/Trust Trust to be established
- Name of Trustee(s)
- Street
- City — State — Zip

IF BUSINESS Complete Business Supplement form in Supplemental Forms Package.

- Proposed Insured(s) Relationship to Entity
- Nature of Business — Business Phone
- Is entity publicly traded? ☐ **YES** ☐ **NO**

IF NO, please supply one of the following documents: *(Indicate which one you are supplying.)*
- ☐ Articles of Incorporation/Government Issued Business License
- ☐ LLC Operating Agreement
- ☐ Partnership Agreement
- ☐ Government Issued Certificate of Good Standing

If more space is needed, please use the Additional Information Section, Page 13.

SECTION 4 Beneficiary(ies)

NOTE: Federal law states if you leave someone with special needs any assets over $2,000, they may lose eligibility for most government benefits.

Contingent Beneficiaries ONLY

☐ Check here if you want any and all living and future natural or adopted children of Proposed Insured #1 to be included as Contingent Beneficiaries. Name any living children as beneficiaries below.

☐ Check here AND DO NOT COMPLETE if Primary Beneficiary is same as Trust or Entity Owner.

☐ **PRIMARY**

Name _____

Street _____

City _____ State _____ Zip _____

Date of Birth _____ SSN/Tax ID _____

If there is a court appointed legal Guardian for Beneficiary, provide name and address in Additional Information Section, Page 13.

Relationship to Proposed Insured(s) _____

Percent of Proceeds _____ (Multiple Beneficiaries will receive an equal percentage of proceeds unless otherwise instructed.)

☐ **PRIMARY** ☐ **CONTINGENT**

Name _____

Street _____

City _____ State _____ Zip _____

Date of Birth _____ SSN/Tax ID _____

Relationship to Proposed Insured(s) _____

Percent of Proceeds _____ (Multiple Beneficiaries will receive an equal percentage of proceeds unless otherwise instructed.)

☐ **PRIMARY** ☐ **CONTINGENT**

Name _____

Street _____

City _____ State _____ Zip _____

Date of Birth _____ SSN/Tax ID _____

Relationship to Proposed Insured(s) _____

Percent of Proceeds _____ (Multiple Beneficiaries will receive an equal percentage of proceeds unless otherwise instructed.)

SECTION 5 Custodian acting for Minor Beneficiary(ies)

Custodian's name _____

as custodian for _____

under the _____ Uniform Transfers [or Gifts] to Minors Act.

Street _____

City _____ State _____ Zip _____

Relationship to Minor(s) _____

SECTION 6 Information Regarding Insurance Applied for

1. PRODUCT & FACE AMOUNT

Product Name Guaranteed Advantage ML

Face Amount $ 10,000,000 *(Complete Personal Financial Supplement if $1,000,000 or more.)*

☐ Group Conversion*

Optional Benefits and Riders:

☐ Guaranteed Survivor Plus Purchase Options (GSPO+)*
Option Period(s): _____ $ _____

☐ Guaranteed Survivor Income Benefit (GSIB)

☐ Term Rider *Specify:* _____ $ _____

☐ Life Guaranteed Purchase Option (LGPO)

☐ Acceleration of Death Benefit Rider (ADBR)*

☐ Enricher Options (PAIR/VABR)* *Specify:* _____ $ _____

☐ Long Term Care Guaranteed Purchase Option (LTC-GPO)

☐ Disability Waiver (DW) *Specify:* _____ $ _____

☐ Other _____

*Complete these forms, if applicable:
- ADBR
- Enricher/Equity Additions
- Group Conversion
- GSPO+

These forms can be found in the Supplemental Forms Package.

Special Requests/Other:

☐ Save Age ☐ Specific Policy Date _____

☐ Other _____

Check here if ☐ alternate **OR** ☐ additional policy is requested and provide full details below. Include **SIGNED & DATED** illustration for each policy requested.

2. ADDITIONAL INFORMATION for WHOLE LIFE PRODUCTS

Do you request automatic payment of premium in default by Policy Loan *(for traditional plans)*, if available? ☐ YES ☐ NO

Dividend Options:

☐ Paid-up Additions ☐ VAI Equity Additions* ☐ Premium Reduction

☐ Cash ☐ Accumulations/DWI

☐ Other _____

3. ADDITIONAL INFORMATION for UNIVERSAL LIFE/VARIABLE LIFE PRODUCTS

For Variable Life, also complete Variable Life Supplement.

Planned Premium Amount: Year 1 $ 456,873 Excess/Lump Sum $ 0

Duration of premium payments 23 years

Planned annual unscheduled payment *(if applicable)*: $ 0

Renewal Premium *(if applicable)*: $ 456,873

Death Benefit Option/Contract Type Option One

Definition of Life Insurance Test: ☐ Guideline Premium Test ☐ Cash Value Accumulation Test
(if available under policy applied for)

Guaranteed to age. *(VUL only)* ☐ 65 ☐ 75 ☐ 85 ☐ 5 years ☐ Other _____

4. ADDITIONAL INFORMATION for QUALIFIED PLANS

Qualified/Non-Qualified Plan number _____

6 **If more space is needed, please use the Additional Information Section, Page 13.**

SECTION 7 Payment Information

If **Monthly Electronic Payment** is chosen, complete Electronic Payment Account Agreement

1. PAYMENT MODE *(Check one)*

Direct Bill: ☑ Annual ☐ Semi-Annual ☐ Quarterly

Electronic Payment: ☐ Monthly

Special Account: ☐ Government Allotment ☐ Salary Deduction

Additional Details: _____

2. SOURCE of CURRENT and FUTURE PAYMENTS *(Check all that apply)*

☐ Earned Income ☐ Mutual Fund/Brokerage Account ☐ Money Market Fund ☑ Savings

☐ Use of Values in another Life Insurance/Annuity Contract ☐ Certificate of Deposit

☐ Loans ☐ Other _____

NOTE:
It is Company policy to not accept cash, traveler's checks, or money orders as a form of payment for Variable Life Products.

3. PAYMENT

Amount collected with application $_____
(Must equal at least one monthly premium.)

Premium Payor:

☐ Proposed Insured #1 ☐ Proposed Insured #2 ☑ Primary Owner

☐ Other

Name _____

Relationship to Proposed Insured(s) and Owner _____

Reason this person is the Payor _____

4. BILLING ADDRESS INFORMATION

☐ Proposed Insured #1 Address ☐ Proposed Insured #2 Address

☑ Primary Owner's Address

☐ Other Premium Payor's/Alternate Billing Address *(Provide details here)*

Street _____

City _____ State _____ Zip _____

☐ Special Arrangements

_____

_____

_____

E-Mail Addresses
(optional)

Proposed Insured #1 _____

Proposed Insured #2 _____

Primary Owner _____

Joint/Contingent Owner _____

SECTION 8 General Risk Questions

If you need more space, please use the Additional Information Section, Page 13

The following questions are to be answered for **ALL** persons to be insured, including those covered by any riders applied for.

1. Within the past three years has **ANY** person to be insured flown in a plane other than as a passenger on a scheduled airline or have plans for such activity within the next year? ☐ **YES** ☑ **NO**

IF YES, complete a separate Aviation Supplement for each applicable Proposed Insured.

2. Within the past three years has **ANY** person to be insured participated in or intend to participate in **any** of the following
Underwater sports - (SCUBA diving, skin diving, or similar activities);
Sky sports - (skydiving, hang gliding, parachuting, ballooning or similar activities);
Racing sports - (motorcycle, auto, motor boat or similar activities);
Rock or mountain climbing or similar activities;
Bungee jumping or similar activities? ☐ **YES** ☑ **NO**

IF YES, complete a separate Avocation Supplement for each applicable Proposed Insured.

3. Within the **next two years** does **ANY** person to be insured **intend to travel** or **reside** outside the U.S. or Canada? ☐ **YES** ☑ **NO**

IF YES, for each occurence, please provide Proposed Insured, duration, country and purpose.

_____

_____

_____

4. CITIZENSHIP/RESIDENCY

A. Are all persons to be insured **U.S. Citizens?** ☑ **YES** ☐ **NO**

IF NO, please provide details:

Proposed Insured(s) _____ Country of Citizenship _____

Visa Type/ID _____ Visa Number _____

Expiration Date _____ Length of Time in U.S. _____

☐ Check here if currently applying for a Social Security number.

B. Are all persons to be insured **permanent residents** of the United States? ☑ **YES** ☐ **NO**

IF NO, please provide details:

Proposed Insured(s) _____

Country of Residence _____

SECTION 8 General Risk Questions *(continued)*

If you need more space, please use the Additional Information Section, Page 13.

The following questions are to be answered for **ALL** persons to be insured, including those covered by any riders applied for.

5. In the last five years, has **ANY** person to be insured used tobacco products (e.g., cigarettes; cigars; pipes; smokeless tobacco; chew; etc.) or nicotine substitutes (e.g., patch, gum)? ☐ **YES** ☑ **NO**

IF YES, please provide details:

Proposed Insured(s) _____ Date Last Used _____

Type _____

Amount/Frequency _____

6. Has **ANY** person to be insured: **EVER** had a driver's license suspended or revoked, **EVER** been convicted of DUI or DWI; or had, in the last five years, any moving violations? ☐ **YES** ☑ **NO**

IF YES, please provide Proposed Insured, date and violation.

Proposed Insured(s) _____

Details: _____

7. Has any person to be insured **EVER** had an application for life, disability income or health insurance declined, postponed, rated or modified or required an extra premium? ☐ **YES** ☑ **NO**

IF YES, please provide details:

Proposed Insured(s) _____

Details: _____

8. Are all persons to be insured: actively at work; or a homemaker performing regular household duties; or a student attending school regularly? ☑ **YES** ☐ **NO**

IF NO, please provide details:

Proposed Insured(s) _____

Details: _____

Please answer these questions **only if requesting the Long Term Care Guaranteed Purchase Option Rider.**

9. LONG TERM CARE GUARANTEED PURCHASE OPTION RIDER

A. Does any person to be insured under this rider currently use any mechanical equipment such as: a walker; a wheelchair; long leg braces; or crutches? ☐ **YES** ☐ **NO**

IF YES, please note which and the reason.

Proposed Insured(s) _____

B. Does any person to be insured under this rider need any assistance or supervision with any of the following activities: bathing; dressing; walking; moving in/out of a chair or bed; toileting; continence; or taking medication? ☐ **YES** ☐ **NO**

Proposed Insured(s) _____

PART II If more space is needed, please use the Additional Information Section, Page 13. 9

SECTION 1 Physician Information

PLEASE NOTE: If FULL PARAMEDICAL exam is required, completion of Medical questions is **OPTIONAL** but will expedite your application

1. PHYSICIAN
Please provide name of doctor, practitioner, or health care facility who can provide the most complete and up to date information concerning the present health of the Proposed Insured(s).

Physician Information for Proposed Insured #1
☐ Check here if no doctor, practitioner or health care facility is known.

Physician Name Slomowits Joseph Md Phone Number (718) 851-8400
Name of Practice/Clinic _____ Fax Number (___) _____
Street 5022 15 Ave
City Brooklyn State NY Zip 11219
Date Last Consulted _____ Reason _____
Findings, treatment given, medication prescribed. If None, check here ☐.

Physician Information ☐ **Proposed Insured #1** ☐ **Proposed Insured #2**
☐ Check here if no doctor, practitioner or health care facility is known.

Physician Name _____ Phone Number (___) _____
Name of Practice/Clinic _____ Fax Number (___) _____
Street _____
City _____ State ___ Zip _____
Date Last Consulted _____ Reason _____
Findings, treatment given, medication prescribed. If None, check here ☐.

SECTION 2 Medical Questions

1. HEIGHT/WEIGHT

Proposed Insured #1 Height _____ Weight _____
Proposed Insured #2 Height _____ Weight _____

Has any Proposed Insured experienced a change in weight (greater than 10 pounds) in the past 12 months? ☐ **YES** ☐ **NO**

IF YES, specify:
Proposed Insured #1 Pounds lost _____ Pounds gained _____
Proposed Insured #2 Pounds lost _____ Pounds gained _____
Reason _____

If more space is needed, please use the Additional Information Section, Page 13.

SECTION 2 Medical Questions

(continued)

PLEASE NOTE: If FULL PARAMEDICAL exam is required, completion of Medical questions is **OPTIONAL** but will expedite your application.

2. Has a parent (P) or sibling (S) of any person to be insured ever had: heart disease; coronary artery disease; high blood pressure; diabetes; or mental illness? ☐ **YES** ☐ **NO**

IF YES, indicate below:

Proposed Insured (#1, #2)	Relationship to Proposed Insured	Age if Living	Age at Death	State of Health, Specific Conditions, Cause of Death
	☐ P ☐ S			
	☐ P ☐ S			
	☐ P ☐ S			
	☐ P ☐ S			

3. Has **ANY** person to be insured **EVER** received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that he/she had:

	Proposed Insured #1		Proposed Insured #2		Other Proposed Insured	
	YES	NO	YES	NO	YES	NO
A. High blood pressure; chest pain; heart attack, or any other disease or disorder of the heart or circulatory system?	☐	☐	☐	☐	☐	☐
B. Asthma; bronchitis; emphysema; sleep apnea; shortness of breath; or any other disease or disorder of the lungs or respiratory system?	☐	☐	☐	☐	☐	☐
C. Seizures; stroke; paralysis; Alzheimer's disease; multiple sclerosis; memory loss; Parkinson's disease; progressive neurological disorder; headaches; or any other disease or disorder of the brain or nervous system?	☐	☐	☐	☐	☐	☐

Details: If you **answered YES** to any of the above questions, please provide details here.

Question Number	Proposed Insured Name	Name of Physician Address if not already provided	Date/Duration of Illness	Diagnosis/Severity Medications/Treatment

SECTION 2 Medical Questions
(continued)

PLEASE NOTE: If FULL PARAMEDICAL exam is required, completion of Medical questions is **OPTIONAL** but will expedite your application

3. Has **ANY** person to be insured **EVER** received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that he/she had:

	Proposed Insured #1		Proposed Insured #2		Other Proposed Insured	
	YES	NO	YES	NO	YES	NO
D. Ulcers; colitis; hepatitis, cirrhosis; or any other disease or disorder of the liver; gallbladder; stomach, or intestines?	☐	☐	☐	☐	☐	☐
E. Any disease or disorder of: the kidney; bladder; or prostate; or blood, protein or pus in the urine?	☐	☐	☐	☐	☐	☐
F. Diabetes; thyroid disorder; or any other endocrine problem(s)?	☐	☐	☐	☐	☐	☐
G. Arthritis; gout; or disorder of the muscles, bones or joints?	☐	☐	☐	☐	☐	☐
H. Cancer; tumor; polyp; cyst or any skin disease or disorder?	☐	☐	☐	☐	☐	☐
I. Anemia; leukemia; or any other disorder of the blood or lymph glands?	☐	☐	☐	☐	☐	☐
J. Depression; stress; anxiety; or any other psychological or emotional disorder or symptoms?	☐	☐	☐	☐	☐	☐
K. Any disease or disorder of the eyes, ears, nose, or throat?	☐	☐	☐	☐	☐	☐

Details: If you **answered YES** to any of the above questions, please provide details here.

Question Number	Proposed Insured Name	Name of Physician Address if not already provided	Date/Duration of Illness	Diagnosis/Severity Medications/Treatment

If more space is needed, please use the Additional Information Section, Page 13.

SECTION 2
Medical Questions
(continued)

PLEASE NOTE:
If FULL PARAMEDICAL exam is required, completion of Medical questions is **OPTIONAL** but will expedite your application.

4. Has **ANY** person to be insured:

	Proposed Insured #1		Proposed Insured #2		Other Proposed Insured	
	YES	NO	YES	NO	YES	NO
A. Currently, or within the past six months, been under observation or received treatment or taken any medication? (Including over-the-counter medications, vitamins, herbal supplements, etc.)	☐	☐	☐	☐	☐	☐
B. For the next six months, scheduled any doctor's visits, medical care, or surgery?	☐	☐	☐	☐	☐	☐
C. During the past five years, had a: checkup; electrocardiogram; chest x-ray; or medical test?	☐	☐	☐	☐	☐	☐
D. During the past five years, had any illness, injury or health condition not revealed above; or have been recommended to have any: hospitalization; surgery; medical test; or medication?	☐	☐	☐	☐	☐	☐
E. EVER been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐	☐	☐	☐	☐
F. EVER used heroin, cocaine, barbituates, or other drugs, except as prescribed by a physician or other licensed practitioner?	☐	☐	☐	☐	☐	☐
G. EVER received treatment from a physician or counselor regarding the use of alcohol, or the use of drugs, except for medicinal purposes; or received treatment or advice from an organization that assists those who have an alcohol or drug problem?	☐	☐	☐	☐	☐	☐

Details: If you **answered YES** to any of the above questions, please provide details here.

Question Number	Proposed Insured Name	Name of Physician Address if not already provided	Date/Duration of Illness	Diagnosis/Severity Medications/Treatment

Additional Information

Use this page for any additional information.
Attach a separate sheet if necessary.

Certification/ Agreement/ Disclosure

Certification Regarding Sales Illustration Agent must check the appropriate statement below.

- ☑ Agent certifies that a signed illustration is **not required** by law or the policy applied for is not illustrated in this state.
- ☐ An illustration was signed and **matches the policy applied for.** It is included with this application.
- ☐ An illustration was shown or provided but is **different from the policy applied for.** An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.
- ☑ **No illustration conforming to the policy** as applied for was shown or provided prior to or at the time of this application. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.
- ☐ If illustration was **only shown on a computer screen,** check and complete details below.

An illustration was displayed on a computer screen. The displayed illustration **matches the policy applied for** but no printed copy of the illustration was provided. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery. The illustration on the screen included the following personal and policy information:

1. Gender (as illustrated) ☐ M ☐ F ☐ Unisex Age _____
2. Rating class (e.g. standard, smoker) ☐ Preferred ☐ Standard ☐ Non-smoker ☐ Smoker ☐ Other _____
3. Type of policy (e.g. L-98, Whole Life) _____
4. Initial Death Benefit $ _____ Death Benefit Option _____
5. Guaranteed Minimum Death Benefit ☐ age 55 ☐ age 65 ☐ age 75 ☐ age 85 ☐ 5 years
6. Dividend Option _____
7. Riders _____ $ _____
   _____ $ _____
   _____ $ _____

Agreement/Disclosure

I have read this application for life insurance including any amendments and supplements and to the best of my knowledge and belief, all statements are true and complete. I also agree that:

- My statements in this application and any amendment(s), paramedical/medical exam and supplement(s) are the basis of any policy issued.
- This application and any: amendment(s); paramedical/medical exam; and supplement(s) to this application, will be attached to and become part of the new policy.
- No information will be deemed to have been given to the Company unless it is stated in this application and paramedical/medical exam, and any supplement(s).
- Only the Company's President, Secretary or Vice-President may: (a) make or change any contract of insurance; (b) make a binding promise about insurance; or (c) change or waive any term of an application, receipt, or policy.
- Except as stated in the Temporary Insurance Agreement and Receipt, no insurance will take effect until a policy is delivered to the Owner and the full first premium due is paid. It will only take effect at the time it is delivered if: (a) the condition of health of each person to be insured is the same as stated in the application; and (b) no person to be insured has received any medical advice or treatment from a medical practitioner since the date of the application.

Certification/ Agreement/ Disclosure

(continued)

- I understand that paying my insurance premiums more frequently than annually may result in a higher yearly out-of-pocket cost or different cash values.
- **If I intend to replace existing insurance or annuities, I have so indicated in Section 2, Question 2 of this application.**
- **I have received the Company's Consumer Privacy Notice and, as required, the Life Insurance Buyer's Guide.**
- **If I was required to sign an HIV Informed Consent Authorization, I have received a copy of that Authorization.**
- I understand that receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. A discount is associated with the acceleration and an administrative charge will be required upon exercise of the benefit.

Taxpayer Identification Number Certification

Under penalties of perjury, I, the Owner, certify that:

The number shown in this application is my correct taxpayer identification number, and I am not subject to backup withholding because:

(a) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, **OR**

(b) the IRS has notified me that I am not subject to backup withholding. *(If you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return, you must cross out and initial this item.)*

I am a U.S. citizen or a U.S. resident alien for tax purposes.

(If you are not a U.S. citizen or a U.S. resident alien for tax purposes, please cross out this certification and complete form W-8BEN).

Please note: The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

SIGNATURES:

If not witnessing all signatures, Witness should sign next to the signature being witnessed.

Signed at City, State Brooklyn NY Date 12/17/07

Proposed Insured #1 Hava Solomon
(age 15 or over)

Signed at City, State _____ Date _____

Proposed Insured #2 _____
(age 15 or over)

Signed at City, State _____ Date _____

Owner _____
(If other than Proposed Insured)
(If age 15 or over) If the Owner is a firm or corporation, include Officer's title with signature.

Signed at City, State _____ Date _____

Parent or Guardian _____
(If Owner or Proposed Insured(s) is/are under 18, sign here if not signed above.)

Signed at City, State Brooklyn NY Date 12/17/07

Witness to Signatures _____
(Licensed Agent/Producer)

Please print Agent/Producer name Mayer Kramarsky

J

Check the appropriate company.

Personal Financial Supplement

Proposed Insured: Hana Salamon

- ☐ Metropolitan Life Insurance Company
- ☐ New England Life Insurance Company
- ☐ MetLife Investors Insurance Company
- ☐ MetLife Investors USA Insurance Company
- ☐ General American Life Insurance Company
- ☐ Metropolitan Tower Life Insurance Company

The Company indicated above is referred to as "the Company".

To be completed when the amount of coverage is $1,000,000 and over.

INCOME

Annual Earned Income

Salary or Draw	$ 100,000.00	
Bonus/Commissions	$	
Other Earnings	$	Source
Total Earned Income	$ 100,000.00	
Spouse's Income	$	

Annual Unearned Income

Dividends/Interest	$ 50,000.00	
Net Rentals	$	
Other Unearned	$	Source
Total Unearned Income	$ 50,000.00	

ASSETS & LIABILITIES

Assets		**Liabilities**	
Cash	$	Mortgages	$
Real Estate	$	Personal Loans	$
Business Equity	$	Other	$
Stocks/Bonds	$		
Other Assets	$ 10,000,000.00		
Total Assets	$ 10,000,000.00	**Total Liabilities**	$

Total Assets	$	10,000,000.00
Total Liabilities	-$	0.00
Net Worth:	=$	10,000,000.00

EFIN-05 (05/05) FF

[redacted]
Stephen Mostecak
Principal Investigator
Fraud Investigation Division
AIG World Investigative Resources
Northeast Region
P.O. Box 372
West Nyack, NY 10994
845.398.0675 - Phone
917.862.2862 - Cell
1.866.667.8514 - (E-fax)

August 6, 2008

Mr. Joel Katz
750 Forest Avenue
Apartment 25D
Lakewood, NJ 08701

Re: Hana Salamon Policy # U10022254L – AIG American General

Mr. Katz:

I am an Investigator for AIG (American Interntional Group)

Stephen Mostecak
Principal Investigator

Hana Salamon Accurint Search w/ SSN of 319.82.9296

Important: The Public Records and commercially available data sources used on reports have errors. Data is sometimes entered poorly, processed incorrectly and is generally not free from defect. This system should not be relied upon as definitively accurate. Before relying on any data this system supplies, it should be independently verified. For Secretary of State documents, the following data is for information purposes only and is not an official record. Certified copies may be obtained from that individual state's Department of State.

Summary Report

Date: 01/23/08
Reference Code: 20080293

Subject Information

Name: HANA SALAMON
Age:
SSN: 090-30-5929 issued in **New York** between **01/01/1954** and **12/31/1957**

Others Associated with SSN:
(DOES NOT usually indicate any type of fraud or deception)
MARTIN SALAMON
DOB: **12/1915** Age: **92**

AKAs (Names Associated with Subject)

[No Data Available]

Indicators

Bankruptcy: **No**
Property: **No**
Corporate Affiliations: **No**

Address Summary (✓ - Probable Current Address)

✓ 4910 17TH AVE APT 2J, BROOKLYN NY 11204-1185, KINGS COUNTY (Jun 2003 - Jan 2008)
Phone at address: (718) 851-9250 **SALAMON MR**
Neighborhood Profile (2000 Census)
Average Age: **34** Median Household Income: **$30,341** Median Home Value: **$667,800** Average Years of Education: **12**

✓ 4910 17TH AVE APT 2Z, BROOKLYN NY 11204-1157, KINGS COUNTY (Jun 2003 - May 2007)
Phone at address: (718) 851-9250 **SALAMON MR**
Neighborhood Profile (2000 Census)
Average Age: **34** Median Household Income: **$30,341** Median Home Value: **$667,800** Average Years of Education: **12**

✓ 4910 17TH AVE APT 4G, BROOKLYN NY 11204-1187, KINGS COUNTY (Oct 1990 - Nov 2006)
Phone at address: (718) 851-9250 **SALAMON MR**
Neighborhood Profile (2000 Census)
Average Age: **34** Median Household Income: **$30,341** Median Home Value: **$667,800** Average Years of Education: **12**

4141 COLLINS AVE APT 109, MIAMI BEACH FL 33140-3238, MIAMI-DADE COUNTY (Feb 2005)
Neighborhood Profile (2000 Census)
Average Age: **42** Median Household Income: **$38,214** Median Home Value: **$367,900** Average Years of Education: **14**

[redacted]
Stephen Mostecak
Principal Investigator
Fraud Investigation Division
AIG World Investigative Resources
Northeast Region
P.O. Box 372
West Nyack, NY 10994
Phone: 845.398.0675
Cell: 917.862.2862
Fax:1.866.667.8514

August 7, 2008

Mr. Aaron Knopfler
750 Forest Avenue
Lakewood, NJ 08701

Re: Life Policy of Hana Salamon - # U10022254L – AIG American General – Issued 12/'07

Mr. Knopfler:

You, as well as Joel Katz, are listed on the above policy of our insured, Hana Salamon. As part of our business practice, I am required to meet with you in person to discuss the Trust aspects of the policy set-up.

As such, kindly call me upon receipt of this letter at the above phone number so that we can schedule an appointment that is convenient for you.

Thank you very much and I anticipate an expedient response, sir.

Stephen Mostecak
Principal Investigator

Office of the City Register

Contents and Index
About ACRIS
About City Register

[Click help for additional instructions]
Selecting a help option will open new window

Current Search Criteria:

Borough: BROOKLYN / KINGS
Block: 05454
Lot: 0045
Date Range: To Current Date
Document Class: All Document Classes

cords 1 - 86 << previous next >> Max Rows 99 [Search Options] [New BBL Search] [Edit Current Search]
nt Index]

View	Reel/Pg/File	CRFN	Lot	Partial	Recorded / Filed	Document Type	Pages	Party1	Party2	Party 3/ Other	More Party 1/2 Names	Corrected/ Remarks	Doc Amou
		2007000416901	45		8/13/2007 12:38:59 PM	UCC3 ASSIGNMENT	4	UNGAR, JACOB	FIRST FINANCIAL EQUITIES, INC.				
		2007000275046	45	ENTIRE LOT	5/25/2007 3:16:28 PM	UCC3 TERMINATION	3	LICHT, SIMON	HSBC MORTGAGE CORPORATION (USA)				
		2007000266680	45	ENTIRE LOT	5/22/2007 2:48:34 PM	BOTH RPTT AND RETT	1	SOUTHBERRY ENTERPRISES LLC	WEINGARTEN, DAVID				132,
		2007000266675	45	ENTIRE LOT	5/22/2007 2:48:11 PM	BOTH RPTT AND RETT	1	SOUTHBERRY ENTERPRISES LLC	WEINGARTEN, DAVID				132,
		2007000232654	45	ENTIRE LOT	5/4/2007 10:32:34 AM	UCC3 AMENDMENT	3	SOUTHBERRY ENTERPRISES, LLC	HERCZL, ARON				
		2007000139116	45	ENTIRE LOT	3/15/2007 11:44:16 AM	INITIAL COOP UCC1	3	LICHT, SIMON	HSBC MORTGAGE CORPORATION USA				
		2007000100069	45	ENTIRE LOT	2/22/2007 11:35:12 AM	BOTH RPTT AND RETT	2	RINGEL, HARRY	BRONNER, CHASKEL				325,
		2007000100068	45	ENTIRE LOT	2/22/2007 11:35:11 AM	POWER OF ATTORNEY	4	RINGEL, MURIEL	MILLER, DEBRA				

2007000100067	45	ENTIRE LOT	2/22/2007 11:35:10 AM	POWER OF ATTORNEY	4	RINGEL, HARRY	MILLER, DEBRA	
2006000544582	45	ENTIRE LOT	9/27/2006 3:26:26 PM	BOTH RPTT AND RETT	2	HOOK, SIMEON	BUCHMAN, HEDY	310,
2006000501377	45	ENTIRE LOT	9/5/2006 4:05:02 PM	INITIAL COOP UCC1	3	LICHT, SIMON	HSBC MORTGAGE CORPORATION (USA)	
2006000361398	45	ENTIRE LOT	6/30/2006 3:09:57 PM	UCC COOPERATIVE ADDENDUM	3	UNGAR, JACOB	INMC MORTGAGE HOLDINGS	
2006000337434	45	ENTIRE LOT	6/15/2006 12:02:03 PM	UCC COOPERATIVE ADDENDUM	2	WEINBERGER, SIMA	CALIFORNIA FEDERAL BANK, A FEDERAL SAVINGS BANK	
2006000331408	45	ENTIRE LOT	6/13/2006 12:35:40 PM	BOTH RPTT AND RETT	1	BERGER, MARK	APPEL, EVA	300,
2006000233842	45	ENTIRE LOT	4/27/2006 9:47:33 AM	INITIAL COOP UCC1	4	LICHT, BELA	M & T MORTGAGE CORPORATION	
2006000071332	45	PARTIAL LOT	2/7/2006 10:48:17 AM	INITIAL UCC1	3	SOUTHBERRY ENTERPRISES, LLC	HERCZL, ARON	
2005000588141	45	ENTIRE LOT	10/20/2005 4:41:46 PM	BOTH RPTT AND RETT	1	ELDIN REALTY COMPANY	SOUTHBERRY ENTERPRISES, LLC	140,
2005000581638	45	ENTIRE LOT	10/19/2005 2:02:00 PM	BOTH RPTT AND RETT	1	ELDIN REALTY COMPANY	SOUTHBERRY ENTERPRISES	140,
2005000505702	45	ENTIRE LOT	9/9/2005 4:35:03 PM	UCC3 TERMINATION	2	HOSCHANDER, MIRIAM	JPMORGAN CHASE BANK	
2005000451816	45	PARTIAL LOT	8/11/2005 1:55:59 PM	INITIAL COOP UCC1	3	HOSCHANDER, MIRIAM	JPMORGAN CHASE BANK, N.A.	
2005000127557	45	ENTIRE LOT	3/3/2005 3:09:24 PM	UCC3 ASSIGNMENT	3	FISCH, ELKY	EVERBANK	
2004000745495	45	PARTIAL LOT	12/2/2004 2:09:29 PM	UCC3 ASSIGNMENT	3	STIEL, FISCHEL	FLEET NATIONAL BANK	
2004000504501	45	ENTIRE LOT	8/13/2004 2:20:27 PM	NYC REAL PROPERTY TRANSFER TAX	2	HERTZ--D/B/A/, SHELDON	GEIGER, SAUL	100,
2004000504492	45	ENTIRE LOT	8/13/2004 2:19:34 PM	NYC REAL PROPERTY TRANSFER TAX	2	HERTZ--D/B/A, SHELDON	GEIGER, SAUL	200,
2004000171943	45	ENTIRE LOT	3/22/2004 3:22:12 PM	INITIAL UCC1	4	4910 17TH AVE. APT. CORP.	NEW YORK COMMUNITY BANK	
2004000171942	45	ENTIRE LOT	3/22/2004 3:22:11 PM	AGREEMENT	14	NEW YORK COMMUNITY BANK	4910 17TH AVE. APT. CORP.	1,200,
2004000171941	45	ENTIRE LOT	3/22/2004 3:22:10 PM	MORTGAGE	9	4910 17TH AVE. APT. CORP.	NEW YORK COMMUNITY BANK	1,200,
2004000171940	45	ENTIRE LOT	3/22/2004 3:22:09 PM	ASSIGNMENT, MORTGAGE	7	J.P. MORGAN INVESTMENT MANAGEMENT, INC.	NEW YORK COMMUNITY BANK	
2004000171939	45	ENTIRE LOT	3/22/2004 3:22:08 PM	TERMINATION OF ASSIGN OF L&R	3	4910 17TH AVE. APT. CORP.	J.P. MORGAN INVESTMENT MANAGEMENT, INC.	
2004000051544	45	ENTIRE LOT	1/28/2004 11:06:43 AM	INITIAL COOP UCC1	2	LICHT, SIMON	WELLS FARGO HOME MORTGAGE, INC.	
2003000425786	45	ENTIRE LOT	10/17/2003 9:59:24 AM	UCC3 TERMINATION	4	STIEL, CHAIM Y	MORTGAGE ELECTRONIC	

							REGISTRATION SYSTEM
	2003000406789	45	ENTIRE LOT	10/2/2003 9:44:19 AM	INITIAL COOP UCC1	3	HOSCHANDER, MIRIAM	JP MORGAN CHASE BANK
	2003000159071	45	ENTIRE LOT	6/6/2003 11:09:00 AM	INITIAL COOP UCC1	3	STIEL, FISCHEL	FLEET NATIONAL BANK
	2003000130468	45	ENTIRE LOT	5/15/2003 9:39:21 AM	INITIAL COOP UCC1	4	SURI, ELIAS	WASHINGTON MUTUTAL BANK, FA
	2003000000345	45	ENTIRE LOT	1/9/2003 4:46:39 PM	INITIAL COOP UCC1	3	FISCH, ELKY	BNY MORTGAGE COMPANY, LLC
02PK09915		45	ENTIRE LOT	11/21/2002	UCC3 AMENDMENT	1	WELZ, ALEXANDER	BNY MORTGAGE COMPANY, LLC
~~5638/1990~~		~~45~~	~~ENTIRE LOT~~	~~5/24/2002~~	DEED	4	LANDAU, BERTA	B LANDAU FAMILY TRUST
02PK01648		45	ENTIRE LOT	3/6/2002	INITIAL COOP UCC1	2	WELZ, ALEXANDER	BNY MORTGAGE COMPANY, LLC
01PK04969		45	ENTIRE LOT	4/11/2001	UCC3 ASSIGNMENT	1	STIEL, CHAIM Y.	BNY MORTGAGE COMPANY, L.L.C.
01PK04321		45	ENTIRE LOT	3/29/2001	INITIAL COOP UCC1	2	STIEL, CHAIM Y.	BNY MORTGAGE COMPANY, L.L.C.
01TK00911		45	ENTIRE LOT	3/27/2001	UCC3 TERMINATION	1	BRACHFELD, MONIQUE	INDEPENDENT NATIONALMORTGAGE CORPORATION
01PK04144		45	ENTIRE LOT	3/27/2001	UCC3 ASSIGNMENT	1	BRACHFELD, MONIQUE	GFI MORTGAGE BANKERS, INC.
01PK03940		45	ENTIRE LOT	3/22/2001	INITIAL COOP UCC1	1	HONIG, MARY	CHASE MANHATTEN BANK
97PK10030		45	ENTIRE LOT	7/31/1997	UCC3 ASSIGNMENT	1	UNGAR, JACOB	FIRST FINANCIAL EQUITIES INC
97PK09917		45	ENTIRE LOT	7/29/1997	INITIAL COOP UCC1	1	UNGAR, JACOB	FIRST FINANCIAL EQUITIES INC
97PK03573		45	ENTIRE LOT	3/20/1997	INITIAL COOP UCC1	2	BRACHFELD, MONIQUE	GFI MORTGAGE BANKERS, INC.
96PK16881		45	ENTIRE LOT	12/26/1996	UCC3 RELEASE	6	HOSCHANDER, DAVID	MONOGRAM HOME EQUITYCORP
96PK16880		45	ENTIRE LOT	12/26/1996	UCC3 RELEASE	9	HOSCHANDER, DAVID	MONOGRAM HOME EQUITYCORP
94PK04908		45	ENTIRE LOT	4/8/1994	UCC3 ASSIGNMENT	1	HOSCHANDER, DAVID	GE CAPITAL MORTGAGESERVICE INC
94PK04907		45	ENTIRE LOT	4/8/1994	UCC3 ASSIGNMENT	1	HOSCHANDER, DAVID	GE CAPITAL MORTGAGESERVICES INC
94PK04822		45	ENTIRE LOT	4/6/1994	INITIAL COOP UCC1	1	HOSCHANDER, DAVID	GE CAPITAL MORTGAGESERVICE INC
94PK04821		45	ENTIRE LOT	4/6/1994	INITIAL COOP UCC1	4	HOSCHANDER, DAVID	GE CAPITAL MORTGAGESERVICES INC
3222/900		45	ENTIRE LOT	2/22/1994	SATISFACTION OF MORTGAGE	2	HERTZ, SHELDON	KRAVCHICK, MAE
3222/729		45	ENTIRE LOT	2/22/1994	ASSIGNMENT, MORTGAGE	3	HERTZ, SHELDON	J.P. MORGAN INVESTMENT MANAGEMENT INC
3222/724		45	ENTIRE LOT	2/22/1994	MORTGAGE	5	4910 17TH AVE APT CORP	J.P. MORGAN INVESTMENT MANAGEMENT INC

3222/411	45	ENTIRE LOT	2/22/1994	ASSIGNMENT, MORTGAGE	9	4910 17TH AVE APT. CORP.	J.P. MORGAN INVESTMENT MANAGEMENT INC
3222/377	45	ENTIRE LOT	2/22/1994	AGREEMENT	36	4910 17TH AVE APT CORP	J.P. MORGAN INVESTMENT MANAGEMENT INC
3222/368	45	ENTIRE LOT	2/22/1994	ASSIGNMENT, MORTGAGE	9	GREEN POINT SAVINGSBANK	J.P. MORGAN INVESTMENT MANAGEMENT INC
94PK01664	45	ENTIRE LOT	2/7/1994	INITIAL UCC1	4	4910 17TH AVE APT CORP	J P MORGAN INVESTMENT MANAGEMENT INC
93TK02024	45	ENTIRE LOT	8/30/1993	UCC3 TERMINATION	2	LANDAU, BERTA	CITIBANK, NA
93PK01980	45	ENTIRE LOT	2/9/1993	INITIAL COOP UCC1	1	LANDAU, BERTA	INDEPENDENCE SAVINGSBANK
92PK14075	45	ENTIRE LOT	9/2/1992	INITIAL COOP UCC1	1	BOORSTEIN, MYRON RONALD	MARINE MIDLAND BANK
2670/1012	45	ENTIRE LOT	2/25/1991	ASSIGNMENT, MORTGAGE	5	HERTZ, HENRY	HERTZ, SHELDON
89PK00667	45	ENTIRE LOT	1/17/1989	INITIAL UCC1	2	LANDAU, BERTA	CITIBANK, NA
8901/667	45	ENTIRE LOT	1/17/1989	UNIFORM COMMERCIAL CODE 1	0	LANDAU, BERTA	CITIBANK NA
2035/2121	45	ENTIRE LOT	6/8/1987	ASSIGNMENT, MORTGAGE	2	KRAVCHICK, HYMAN/LWT	ELDIN REALTY CO
1845/519	45	ENTIRE LOT	7/16/1986	ASSIGNMENT, MORTGAGE	4	HERTZ, SHELDON	HERTZ, HENRY
1845/514	45	ENTIRE LOT	7/16/1986	ASSIGNMENT, MORTGAGE	5	ELDIN RLTY COMP	HERTZ, HENRY
1797/1500	45	ENTIRE LOT	4/17/1986	MORTGAGE	10	4910 17TH AVE APT CORP	ELDIN RLTY CO 800,
1797/1498	45	ENTIRE LOT	4/17/1986	DEED	2	ELDIN RLTY CO	4910 17TH AVE APT.CORP
1327/1186	45	ENTIRE LOT	7/20/1982	DEED	2	HERTZ, SHELDON	ELDIN REALTY COMPANY
1325/1053	45	ENTIRE LOT	7/9/1982	MORTGAGE	5	HERTZ, SHELDON	KRAVCHICK, HYMAN DECD 300,
1325/1051	45	ENTIRE LOT	7/9/1982	DEED	2	KRAVCHICK, HYMAN DECD	HERTZ, SHELDON
918/523	45	ENTIRE LOT	5/5/1977	DEED	2	RAYTY REALTY CORP	MITGAG SHIRLEY
918/15	45	ENTIRE LOT	5/4/1977	SUNDRY AGREEMENT	5	THE GREEN POINT SAV BANK	
918/12	45	ENTIRE LOT	5/4/1977	ASSIGNMENT, MORTGAGE	3	DOLLAR SAVINGS BANK OF NEW YORK	THE GREEN POINT SAV BANK
918/7	45	ENTIRE LOT	5/4/1977	MORTGAGE	5	RAYTY REALTY CORP	THE GREEN POINT SAVINGS BANK
918/5	45	ENTIRE LOT	5/4/1977	DEED	2	MITGANG SHIRLEY AS TRUSTEE OF	RAYTY REALTY CORP
569/261	45	ENTIRE LOT	7/14/1972	SUNDRY AGREEMENT	13	RUTCO RLTY CORP	

534/735	45	ENTIRE LOT	1/25/1972	DEED	2	RUTCO REALTY CORP	MITGANG SHIRLEY AS TRUSTEE OF
533/1950	45	ENTIRE LOT	1/24/1972	AGREEMENT	4	RUTCO REALTY CORP	DOLLAR SAVINGS BANK
533/1945	45	ENTIRE LOT	1/24/1972	MORTGAGE	5	RUTCO REALTY CORP	DOLLAR SAVS BANK OF NYC
533/1941	45	ENTIRE LOT	1/24/1972	ASSIGNMENT, MORTGAGE	2	HARLEM SAVS BANK	DOLLAR SAVS BANK
532/1521	45	ENTIRE LOT	1/18/1972	DEED	2	MITGANG SHIRLEY TRUSTEE OF	RUTCO REALTY CORP
463/1492	45	ENTIRE LOT	2/5/1971	DEED	2	RUTCO RLTY CORP	MITGANG SHIRLEY AS TRUSTEE OF
459/1049	45	ENTIRE LOT	1/19/1971	DEED	2	MITGANG SHIRLEY AS TRUSTEE OF	RUTCO RLTY CORP

New Parcel Identifier Search

From: Mostecak, Stephen
Sent: Thursday, July 17, 2008 3:36 PM
To: 'Pinchas Geller, CPA'
Subject: RE: Hana Salamon
Dear Mr. Geller:

As you are aware, I am conducting an investigation regarding an American General life insurance policy insuring the life of one of your clients, Hana Salamon. As part of my investigation, I have contacted you numerous times (once in an in-person interview) in an attempt to solicit information from you to confirm the accuracy of financial representations in Ms. Salamon's life insurance application. However, rather than provide information to verify Ms. Salamon's representations in her life insurance application, you have refused to cooperate with the investigation. If you have information that can establish the accuracy of the financial representations in Ms. Salamon's application, please provide it by Friday, July 18, 2008. If we do not receive information from you by July 18th, we will assume that no such information exists.

Stephen J. Mostecak
Principal Investigator
AIG World Investigative Resources (AIGWIR)
Fraud Investigation Division
P.O. Box 372
West Nyack, NY 10994
Office: 845.398.0675; E-Fax: 1.866.667.8514
Cell: 917.862.2862
E/Mail: Stephen.Mostecak@AIG.com
F.I.D. Intranet Site: <http://aignetprod.aig.com/cffid>

From: Pinchas Geller, CPA [mailto:pinnygcpa@gmail.com]
Sent: Thursday, July 17, 2008 10:18 AM
To: Mostecak, Stephen
Subject: RE: Hana Salamon

Mr. Mostecak

I would very much want to assist you in your investigation, however, I determined that me talking to you would be in violation of IRC and AICPA code of professional standards. I reviewed the Internal Revenue Code and the AICPA code of professional standards. According to IRC Section 7216 and AICPA rule 301 I can't disclose any information of my clients without their specific consent. Violation of IRC 7216 is subject to a fine or imprisonment or both.

Respectfully,
Pinchas Geller, CPA

From: Mostecak, Stephen [mailto:Stephen.Mostecak@AIG.com]
Sent: Wednesday, July 16, 2008 4:39 PM
To: 'PGeller@PGellerCPA.com'
Subject: Hana Salamon

Mr. Geller:

Thanks for taking the time and meeting with me today regarding my investigation of the life policy issuance of Hana Salamon.

Kindly contact me as soon as possible once you locate your file on Hana Salamon that depicts her real estate property ownership that you verified to the investigator from Infolink Services, John Vega, and which AIG American General based the issuance of the policy on.

Thanks very much.

Stephen J. Mostecak
Principal Investigator
AIG World Investigative Resources (AIGWIR)
Fraud Investigation Division
P.O. Box 372
West Nyack, NY 10994
Office: 845.398.0675; E-Fax: 1.866.667.8514
Cell: 917.862.2862
E/Mail: Stephen.Mostecak@AIG.com
F.I.D. Intranet Site: <http://aignetprod.aig.com/cffid>

Note to AIGWIR Files:

20080289 Moses Feder
20080290 Agi Fliegman
20080291 Alvin Lapides
20080292 Lola Lieber-Schwartz
20080293 Hana Salamon

1/22/2008:

S/W Jim Bilello of MetLife who made inquiries as to existing or applied for coverage of the above 5 individuals.

I advised him that I did not show any EXISTING coverage with the exception of Hana Salamon, policy # U10022254L, for $8.5M. Note that the SSN used by Hana Salamon for MetLife is 319.82.9296 and that Mr. Bilello's Acurint search reveals an SSN for her as 090.30.5929. It should further be noted that the last 4 SSN digits on AIG's policy for Hana Salamon is 9295. MetLife has NOT YET issued on Hana Salamon.

I sent inquiries to Mary Cummings of AIGWIR to determine if any applied for coverage existed and if so to obtain the policy applications.

Jim Bilello advised that the Agents on his policies were MAYER KRAMARSKY and LAZER LEVI. Our Agent on the Salamon policy is Halpert Yitzchok.

Mr. Bilello advised that he knows that Moses Feder did apply (application signed) on 12/9/07 to American General for 10M.

Hana Salamon's application was signed on 12/17/2007, which is post AIG's application date of 12/13/2007. AIG issued on 12/28/2007 on Ms. Salamon.

Mr. Bilello advised that the Brokerage/Broker for his 5 proposed insureds, Lifemark, applied for $10M for each of the five and asked if MetLife could waive the stress tests of the 5 insureds, which was denied. The Broker then came back and said, in essence, "OK, we'll apply for $5M on each.

MetLife advised that in an attempt to verify income and net worth, the insured, Hana Salamon, advised that her income is $100K a year, as well as $50K of unearned income and that she had a Net Worth of $10M. She said that she is a self-employed ARTIST.

I have asked AG (via Ofelia Gonzales) for a copy of the complete policy file on Hana Salamon, and I have asked AIGWIR's Mary Cummings to check on all APPLIED FPR coverage on all 5 people.

The 5 named individuals from MetLife appear at the end of this document, as is the Policy Summary Page.

Investigation to continue and I will notify Sr. Counsel Katherine Easterby of the MetLife request.

Jan 22 08 01:44p Stephen Mostecak 845-308-0675 p.1

Page 1 of 1 received at 1/22/2008 11:28:49 AM [Eastern Standard Time] on server AS-EXTFAX-SY006.

MetLife Insurance

To:	Steve Mostecak
Company:	AIG
Date:	January 22, 2008
From:	Jim Bilello
Fax Number:	(908) 655-9901
Business Number:	(732) 326-5138
E-Mail	jbilello@metlife.com

Steve,

MetLife is reviewing the underwriting for a recently applied and/or issued policy to determine whether undisclosed coverage may have existed at the time of issue. Our records indicate that this application may have been shopped for competitive premium bids and that AIG may have received an application. Please advise whether AIG has issued on the following individual and, if so, please provide the face amount, date of issue and agent of record:

	Policy Number	First Name	Last Name	SS#	DOB
1	208003440	Moses (Moshe)	Feder	110-30-0737	2/28/1928
2	207286236	Agi (Agnes)	Fliegman	063-36-6579	3/15/1931
3	207286192	Alvin	Lapides	104-22-5850	6/13/1931
4	208001252	Lola	Lieber-Schwartz	062-28-4378	3/15/1923
* 5	208001896	Hana	Salamon	319-62-9298	1/12/1931

Accurint lists Ms. Salamon's ss# as 090-30-5929

Please feel free to contact me directly if you need additional information. Thank you!

01/22/2008 11:23 7323263316 COC PAGE 01

<<Policy List<< | Summary | Documents | Policies | Activity

Pending Summary for Policy U10022254L - HANA SALAMON

Inforce as of 12-31-2007 Last Activity on 12-31-2007 Current as of 01-22-2008

Insured Names

	Insured Name	SSN	Sex	Birth Date	Issue Age	Underwriting Class/Rating
Primary	HANA SALAMON	929[illegible]	Female	01-21-1931	77	Standard Non-Tobacco

Coverage

Death Benefit Option Level

Coverage Name / Rating	Face Amount	Annual Premium	Issued	Matures/ Expires
ELITE UL 2003-GL	8,500,000	289,680.00	12-28-2007	12-28-2030

Underwriting

Underwriter Name	Application Received	Application Signed	Cash Received
Amy Frazer	12-21-2007	12-13-2007	0.00

Requirement / Comment	Insured	Date Added	Date Received
AN EXPANDED INSPECTION REPORT HAS BEEN REQUESTED	Primary	12-21-2007	12-21-2007
ATTENDING PHYSICIAN'S STATEMENT *BROOKLYN NUCLEAR IMAGING*	Primary	12-21-2007	12-21-2007
BLOOD PROFILE *OLDER AGE PROFILE*	Primary	12-21-2007	12-21-2007
ELECTROCARDIOGRAM	Primary	12-21-2007	12-21-2007
EXAM BY PHYSICIAN	Primary	12-21-2007	12-21-2007
FUNCTIONAL TESTING IS REQUIRED AS PART OF THE EXAMINATION	Primary	12-21-2007	12-21-2007
HIPAA AUTHORIZATION TO OBTAIN AND DISCLOSE INFO IS REQUIRED	Primary	12-21-2007	12-21-2007
HIV FORM	Primary	12-21-2007	12-21-2007
HOME OFFICE URINE SPECIMEN *OLDER AGE PROFILE*	Primary	12-21-2007	12-21-2007
MISCELLANEOUS *AGENT CERTIFICATION FORM AGLC101994*	Primary	12-21-2007	12-21-2007
MISCELLANEOUS *PREMIUM FINANCING DISCLOSURE FORM AGLC102053*	Primary	12-21-2007	12-21-2007
NAIC REPLACEMENT FORM	Primary	12-21-2007	12-21-2007
APPLICATION *TO INCLUDE OWNER/BENE INFORMATION*	Primary	12-21-2007	12-27-2007
MISCELLANEOUS *PLEASE VERIFY SPELLING OF INSUREDS NAME*	Primary	12-21-2007	12-27-2007
SIGNED ILLUSTRATION *A SIGNED ILLUSTRATION IS NEEDED FOR ISSUE IN NAIC STATE*	Primary	12-21-2007	12-27-2007
RELEASED BY UNDERWRITING	Primary	12-28-2007	12-28-2007
AMENDMENT OF APPLICATION	Primary	12-28-2007	12-31-2007
CASH *ANNUAL PREMIUM $366,690.00*	Primary	12-28-2007	12-31-2007
MISCELLANEOUS *CANCELLATION WILL OCCUR ON 01/28/2008*	Primary	12-28-2007	12-31-2007

Billing

Billing Method	Frequency	Amount
Direct Bill (Code I)	Annual	366,690.00

Premium Options	Minimum	Planned
Annual	289,680.00	366,690.00
Semiannual	144,840.00	183,345.00
Quarterly	72,420.00	91,672.50

Guideline Single Premium	6,119,178.22
Guideline Level Premium	900,999.84
Seven Pay Premium	1,138,297.84
Internal Exchange Value	0.00
External Exchange Value	0.00
Lump Sum Deposit	0.00

1/22/2008

NARRATIVE FOR IFB REFERRAL – HANA SALAMON

AIG developed intelligence that one of our insured's, Hana Salamon, may have recently taken out a life insurance policy for $8.5M and that there may be certain intentional material misrepresentations on the life policy application concerning the insured's finances. It is further believed that the Broker, Halpert Yitzchok, may be complicit in the misrepresentations on the policy application. This appears to be an Investor Owned Life Insurance (IOLI) investigation wherein an elderly insured is offered an incentive to take out a high dollar life policy, and then, post the 2-year contestability period, the policy will be sold to investors and the death benefit will go to the investors. In the IOLI scenario, the insured takes out the policy with the intent to sell the policy and with that sale, violates the insurable interest statutes.

In this investigation, our insured applied for and was issued a $8.5M life policy # U10022254 on 12/28/2007. She represented that she has a net worth of $14M and annual earned income of between $150K and $360K, and unearned income of $470K. Our insured's DOB: is 1.21.1931. She also represented that she is an artist and has her own company called Hana's Gallery.

I will attach copies of the financial representations that were provided to AIG by the insured and broker.

Investigation has disclosed no evidence of any such assets. I have visited this insured at her residence, which is a coop apartment in Brooklyn (not sure if she owns the apartment or not), with a value, where she to own it, of approx. $215K. My repeated calls to her apartment at 718.851.9250 have not produced any return calls despite my leaving messages. There is a male voice on the answering machine stating, "This is Salamon residence."

I have sent a UPS overnight letter of my request for contact, which I have tracked with a delivery date of 2/8/08. No response elicited.

PINCHAS M. GELLER - ACCOUNTANT FOR HANA SALAMON

Comprehensive Report

Comprehensive Report
Date: 06/27/08
Reference Code: 20080293

Report Legend:
S - Shared Address
D - Deceased
✓ - Probable Current Address

Subject Information

Name: PINCHAS M GELLER
Date of Birth: **10/27/1968**
Age: **39**
SSN: 073-60-4657 issued in **New York** between **1/1/1977** and **12/31/1978**
View All SSN Sources

AKAs (Names Associated with Subject)

PINCHAS GELLER
Age: **39** SSN: 073-60-xxxx

Indicators

Bankruptcy: **No**
Property: **No**
Corporate Affiliations: **No**

Address Summary

✓ 1014 46TH ST APT 3, BROOKLYN NY 11219-2401, KINGS COUNTY (Jul 1999 - Jun 2008)

✓ 1227 51ST ST STE B1, BROOKLYN NY 11219-6512, KINGS COUNTY (Feb 2006 - Apr 2008)

1280 56TH ST APT 3, BROOKLYN NY 11219-4500, KINGS COUNTY (Jul 1999 - Jan 2007)
Phone at address: 718-853-7727 **MEISELS JOEL**

1280 56TH ST APT 2R, BROOKLYN NY 11219-4500, KINGS COUNTY (Aug 1993 - Jan 2007)

5293 STATE ROUTE 42, SOUTH FALLSBURG NY 12779-5726, SULLIVAN COUNTY (Jul 2005 - Sep 2005)
Phone at address: 845-434-9595 **FOGEL MEIR**
845-436-5327 **BERGER MARILYN**
845-434-8258 **GRUM HERSCHEL**

1280 ST APT 562R, BROOKLYN NY 11201, KINGS COUNTY (Feb 2000)

Others Associated With Subjects SSN:

(DOES NOT usually indicate any type of fraud or deception)
[None Found]

Comprehensive Report Summary: (Click on Link to see detail)

Bankruptcies:
None Found
Liens and Judgments:
None Found

UCC Filings:
None Found
Phones Plus:
None Found
People at Work:
37 Found
Driver's License:
None Found
Address(es) Found:
2 Verified and 4 Non-Verified Found
Possible Properties Owned:
None Found
Motor Vehicles Registered:
6 Found
Watercraft:
None Found
FAA Certifications:
None Found
FAA Aircrafts:
None Found
Possible Criminal Records:
None Found
Sexual Offenses:
None Found
Florida Accidents:
None Found
Professional Licenses:
None Found
Voter Registration:
1 Found
Hunting/Fishing Permit:
None Found
Concealed Weapons Permit:
None Found
Possible Associates:
None Found

Bankruptcies:

[None Found]

Liens and Judgments:

[None Found]

UCC Filings:

[None Found]

Phones Plus(s):

[None Found]

People at Work:

Name: PINCHAS GELLER
Title: PRES
SSN: 073-60-xxxx
Company: ACE CONSULTING LPC SRVC
Address: BROOKLYN, NY
Phone:
FEIN:
Dates: Aug 30, 2005 - Sep 12, 2007
Confidence: High

Name: PINCHAS GELLER
Title: PROCESS ADDRESS CONTACT
SSN: 073-60-xxxx
Company: C & S REALTY OF NY CORP
Address: 1227 51ST ST # B, BROOKLYN NY 11219-3507
Phone:
FEIN:
Dates: Jun 27, 2005 - Jul 30, 2007
Confidence: High

Name: PINCHAS GELLER
Title: PROCESS ADDRESS CONTACT

SSN: 073-60-xxxx
Company: A - 1 KOSHER SALES CORP
Address: 1227 51ST ST # B, BROOKLYN NY 11219-3507
Phone:
FEIN:
Dates: Jun 27, 2005 - Jul 30, 2007
Confidence: High

Name: PINCHAS GELLER
Title: CHAIRMAN OR CHIEF EXECUTIVE OFFICER
SSN: 073-60-xxxx
Company: ACE CONSULTING L & P SERVICES INC
Address:
Phone: 718-871-5228
FEIN:
Dates: Jul 18, 2003 - Jul 30, 2007
Confidence: High

Name: PINCHAS GELLER
SSN: 073-60-xxxx
Company: ACE CONSULTING L P SERVICES INC
Address: 1014 46TH ST STE 3, BROOKLYN NY 11219-2401
Phone: 718-853-9612
FEIN:
Dates: Jul 1, 2003 - Jul 1, 2007
Confidence: Medium

Name: PINCHAS GELLER
Title: PRESIDENT
SSN: 073-60-xxxx
Company: ACE CONSULTING LPC SRVC
Address: BROOKLYN, NY
Phone:
FEIN:
Dates: Jun 30, 2005
Confidence: High

Name: PINCHAS M GELLER
SSN: 073-60-xxxx
Company: JACOB GLICK CPA PC
Address: 1454 42ND ST, BROOKLYN NY 11219-1523
Phone: 718-972-0187
FEIN:
Dates: Sep 1, 2000 - Jun 1, 2001
Confidence: Medium

Name: PINCHAS GELLER
Title: CONTACT
SSN: 073-60-xxxx
Company: SIYATA DISHMAYA CORP
Address: 1014 46TH ST STE 3, BROOKLYN NY 11219-2401
Phone: 718-853-9612
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: JD LEAD CONSULTANTS INC
Address: 4515 12TH AVE APT B6, BROOKLYN NY 11219-2009
Phone: 718-981-1984
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: CONTACT
SSN: 073-60-xxxx
Company: SUPERIOR DESIGN & PRINTING CORP

Address: 1014 46TH ST STE 3, BROOKLYN NY 11219-2401
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: CONTACT
SSN: 073-60-xxxx
Company: B & R DISTRIBUTORS CORP
Address: 694 E 7TH ST, BROOKLYN NY 11218-5904
Phone: ✓ 718-686-0227
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: CONTACT
SSN: 073-60-xxxx
Company: BROOKLYN WOODWORKER SUPPLY INC
Address: 90 WATERBURY ST, BROOKLYN NY 11206-1618
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: CONTACT
SSN: 073-60-xxxx
Company: EITS CORP
Address: 90 WATERBURY ST, BROOKLYN NY 11206-1618
Phone: 718-853-9612
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: CONTACT
SSN: 073-60-xxxx
Company: QUICKAEROBICS INC
Address: 1014 46TH ST, BROOKLYN NY 11219-2401
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: CONTACT
SSN: 073-60-xxxx
Company: TRISTATE POWER WASHING CORP
Address: 1014 46TH ST, BROOKLYN NY 11219-2401
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: CONTACT
SSN: 073-60-xxxx
Company: TRAVEL PROTECTION INC
Address: 1116 44TH ST, BROOKLYN NY 11219-1833
Phone: 718-853-9612
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx

Company: ABARMO PRODUCTS CORP
Address: 1227 51ST ST STE B1, BROOKLYN NY 11219-6512
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: A & H SALES INC
Address: 1227 51ST ST STE B1, BROOKLYN NY 11219-6512
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: MOBILE MEDIA GROUP INC
Address: 240 52ND ST, BROOKLYN NY 11220-1715
Phone: ✓718-439-4647
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: J & J REALTY CONSULTING CORP
Address: 1227 51ST ST STE B1, BROOKLYN NY 11219-6512
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: WILCAR TOURS INC
Address: 8114 BAXTER AVE APT 5G, ELMHURST NY 11373-1310
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: MAJOR VARIETY CORP
Address: 1710 59TH ST, BROOKLYN NY 11204-2242
Phone: 718-853-9612
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: LENA DESIGNS INC
Address: 4912 13TH AVE, BROOKLYN NY 11219-3134
Phone: 718-853-9612
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT

SSN: 073-60-xxxx
Company: MO EQUITIES CORP
Address: 1227 51ST ST STE B1, BROOKLYN NY 11219-6512
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: AMERICAN FRIENDS OF THE TOLNA ASSOCIATION FOR JEWI
Address: 1227 51ST ST STE B1, BROOKLYN NY 11219-6512
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: HOME IMPROVEMENT GROUP INC
Address: 240 52ND ST, BROOKLYN NY 11220-1715
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: SELECTEL INC
Address: 152 S 9TH ST, BROOKLYN NY 11211-8720
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: TRANSIT MEDIA GROUP INC
Address: 240 52ND ST, BROOKLYN NY 11220-1715
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: MEKACH TOV ENTERPRISES INC
Address: 5014 16TH AVE STE 321, BROOKLYN NY 11204-1404
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER CPA
Title: AGENT
SSN: 073-60-xxxx
Company: RAV TIV LLC
Address: 1312 44TH ST STE 121, BROOKLYN NY 11219-2108
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT

SSN: 073-60-xxxx
Company: SAVE ON TONERS INC
Address: 946 45TH ST, BROOKLYN NY 11219-1701
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: METRO DOORS INC
Address: 965 50TH ST, BROOKLYN NY 11219-3310
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: A-1 PARTY & TENT RENTALS INC
Address: 1111 ROGERS AVE, BROOKLYN NY 11226-7107
Phone: 718-789-9200
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: STAR DOORS HARDWARE INC
Address: 1275 38TH ST, BROOKLYN NY 11218-1928
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: H C A P INC
Address: 938 51ST ST, BROOKLYN NY 11219-3316
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER
Title: AGENT
SSN: 073-60-xxxx
Company: PISCHU LI KIRUV KEROVIM INC
Address: 1227 51ST ST STE B1, BROOKLYN NY 11219-6512
Phone:
FEIN:
Dates:
Confidence: High

Name: PINCHAS GELLER CPA
Title: CONTACT
SSN: 073-60-xxxx
Company: CHASDEI DAVID INC
Address: 1227 51ST ST STE B1, BROOKLYN NY 11219-6512
Phone:
FEIN:
Dates:
Confidence: High

Driver's License Information:

[None Found]

Address Summary: View All Address Variation Sources

✓ 1014 46TH ST APT 3, BROOKLYN NY 11219-2401, KINGS COUNTY (Jul 1999 - Jun 2008)
✓ 1227 51ST ST STE B1, BROOKLYN NY 11219-6512, KINGS COUNTY (Feb 2006 - Apr 2008)
1280 56TH ST APT 3, BROOKLYN NY 11219-4500, KINGS COUNTY (Jul 1999 - Jan 2007)
1280 56TH ST APT 2R, BROOKLYN NY 11219-4500, KINGS COUNTY (Aug 1993 - Jan 2007)
5293 STATE ROUTE 42, SOUTH FALLSBURG NY 12779-5726, SULLIVAN COUNTY (Jul 2005 - Sep 2005)
1280 ST APT 562R, BROOKLYN NY 11201, KINGS COUNTY (Feb 2000)

Active Address(es): View All Address Variation Sources

✓ 1014 46TH ST APT 3, BROOKLYN NY 11219-2401, KINGS COUNTY (Jul 1999 - Jun 2008)
Current Residents at Address:
LEAH Z GELLER
PINCHAS M GELLER

✓ 1227 51ST ST STE B1, BROOKLYN NY 11219-6512, KINGS COUNTY (Feb 2006 - Apr 2008)

Previous And Non-Verified Address(es): View All Address Variation Sources

1280 56TH ST APT 3, BROOKLYN NY 11219-4500, KINGS COUNTY (Jul 1999 - Jan 2007)
Current Residents at Address:
JOEL MEISELS
MEISELS JOEL 718-853-7727

1280 56TH ST APT 2R, BROOKLYN NY 11219-4500, KINGS COUNTY (Aug 1993 - Jan 2007)

5293 STATE ROUTE 42, SOUTH FALLSBURG NY 12779-5726, SULLIVAN COUNTY (Jul 2005 - Sep 2005)
Current Residents at Address:
YECHIEL MYSKI
AVRHOM RABINOWITZ
BELLA AUSCH
DAVID JAROSLAWICZ
HERSCHEL GRUM
MARTIN REICHMAN
SHANA REICHMAN
YAAKOV AUSCH
JOSHUA MACK JAROSLAWICZ
Current phones listed at this address:
FOGEL MEIR 845-434-9595
BERGER MARILYN 845-436-5327
GRUM HERSCHEL 845-434-8258
845-434-9542

1280 ST APT 562R, BROOKLYN NY 11201, KINGS COUNTY (Feb 2000)

Possible Properties Owned by Subject:

[None Found]

Motor Vehicles Registered To Subject:

Vehicle:
Description: 2006 Toyota SIENNA - Sport Van
VIN: 5TDZA23C16S521398
State Of Origin: NEWYORK
Engine: 6 Cylinder 201 Cubic Inch
Anti Lock Brakes: 4 wheel standard
Air Conditioning: Standard
Daytime Running Lights: Not available
Power Steering: Standard
Power Brakes: Standard
Power Windows: Standard
Security System: Keyless Entry and Al
Roof: None / not available
Price: 23625
Radio: AM/FM CD
Front Wheel Drive: Yes
Four Wheel Drive: No
Tilt Wheel: Standard

Registrant(s)
Record Type: CURRENT

Name: PINCHAS GELLER
Potential SSN: 073-60-xxxx
Address: 1014 46TH ST 3, BROOKLYN NY 11219-2401, KINGS COUNTY
Tag Number: CGZ6899
Earliest Registration Date: 7/27/2006
Latest Registration Date: 3/27/2007
Expiration Date: 3/18/2009
License Plate Type: Private

Vehicle:
Description: 2006 Dodge GRAND CARAVAN - Sport Van
VIN: 2D4GP44L56R854375
State Of Origin: NEWYORK
Engine: 6 Cylinder 230 Cubic Inch
Anti Lock Brakes: 4 wheel standard
Air Conditioning: Standard
Daytime Running Lights: Optional
Power Steering: Standard
Power Brakes: Standard
Power Windows: Standard
Security System: Sentry Key and Alarm
Roof: None / not available
Price: 27100
Radio: AM/FM Cassette/CD
Front Wheel Drive: Yes
Four Wheel Drive: No
Tilt Wheel: Standard

Registrant(s)
Record Type: CURRENT
Name: PINCHAS GELLER
Potential SSN: 073-60-xxxx
Address: 1014 46TH ST 3, BROOKLYN NY 11219-2401, KINGS COUNTY
Tag Number: DRP9590
Earliest Registration Date: 6/7/2006
Latest Registration Date: 6/7/2006
Expiration Date: 6/6/2008
License Plate Type: Private

Vehicle:
Description: Black 1999 Pontiac MONTANA - Extended Sport Van
VIN: 1GMDX03E1XD156860
State Of Origin: NEWYORK
Engine: 6 Cylinder 204 Cubic Inch
Anti Lock Brakes: 4 wheel standard
Air Conditioning: Standard
Daytime Running Lights: Standard
Power Steering: Standard
Power Brakes: Standard
Power Windows: Optional
Security System: Pass key
Roof: None / not available
Price: 23875
Radio: AM/FM
Front Wheel Drive: Yes
Four Wheel Drive: No
Tilt Wheel: Standard

Registrant(s)
Record Type: HISTORICAL
Name: PINCHAS GELLER
Potential SSN: 073-60-xxxx
Address: 1014 46TH ST 3, BROOKLYN NY 11219-2401, KINGS COUNTY
Tag Number: CGZ6899
Earliest Registration Date: 3/19/2003
Latest Registration Date: 3/17/2005

Expiration Date: 3/18/2007
License Plate Type: Private

Vehicle:
Description: Black 1999 Pontiac MONTANA - Extended Sport Van
VIN: 1GMDX03E1XD156860
State Of Origin: NEWYORK
Engine: 6 Cylinder 204 Cubic Inch
Anti Lock Brakes: 4 wheel standard
Air Conditioning: Standard
Daytime Running Lights: Standard
Power Steering: Standard
Power Brakes: Standard
Power Windows: Optional
Security System: Pass key
Roof: None / not available
Price: 23875
Radio: AM/FM
Front Wheel Drive: Yes
Four Wheel Drive: No
Tilt Wheel: Standard

Owner(s)
Name: PINCHAS GELLER
Potential SSN: 073-60-xxxx
Address: 1014 46TH ST 3, BROOKLYN NY 11219-2401, KINGS COUNTY
Title Issue Date: 5/14/2003

Lien Holder(s)
None

Vehicle:
Description: 1990 Pontiac BONNEVILLE - Sedan 4 Door
VIN: 1G2HZ54C5L1247687
State Of Origin: NEWYORK
Engine: 6 Cylinder 231 Cubic Inch
Anti Lock Brakes: 4 wheel optional
Air Conditioning: Standard
Daytime Running Lights: Not available
Power Steering: Standard
Power Brakes: Standard
Power Windows: Standard
Security System: None
Roof: None / not available
Price: 19144
Radio: AM/FM
Front Wheel Drive: Yes
Four Wheel Drive: No
Tilt Wheel: Standard

Registrant(s)
Record Type: HISTORICAL
Name: PINCHAS GELLER
Potential SSN: 073-60-xxxx
Address: 1280 56TH ST APT 3, BROOKLYN NY 11219-4500, KINGS COUNTY
Tag Number: D917DV
Earliest Registration Date: 7/1/1999
Latest Registration Date: 7/1/1999
Expiration Date: 7/12/2001
License Plate Type: Private

Vehicle:
Description: 1990 Pontiac BONNEVILLE - Sedan 4 Door
VIN: 1G2HZ54C5L1247687
State Of Origin: NEWYORK
Engine: 6 Cylinder 231 Cubic Inch

Anti Lock Brakes: 4 wheel optional
Air Conditioning: Standard
Daytime Running Lights: Not available
Power Steering: Standard
Power Brakes: Standard
Power Windows: Standard
Security System: None
Roof: None / not available
Price: 19144
Radio: AM/FM
Front Wheel Drive: Yes
Four Wheel Drive: No
Tilt Wheel: Standard

Owner(s)
Name: PINCHAS GELLER
Potential SSN: 073-60-xxxx
Address: 1280 56TH ST APT 2R, BROOKLYN NY 11219-4500, KINGS COUNTY
Title Issue Date: 6/29/1999

Lien Holder(s)
None

Watercraft:
[None Found]

FAA Certifications:
[None Found]

FAA Aircrafts:
[None Found]

Possible Criminal Records:
[None Found]

Sexual Offenses:
[None Found]

Florida Accidents:
[None Found]

Professional License(s):
[None Found]

Voter Registration:
Name: PINCHAS M GELLER
Address: 1014 46TH ST, BROOKLYN NY 11219-2401
DOB: 10/27/1968
Gender: Male
Last Vote Date: 11/7/2006
Political Party: DEMOCRAT
State of Registration: New York
Status: ACTIVE

Hunting/Fishing Permit:
[None Found]

Concealed Weapons Permit:
[None Found]

Possible Associates:
[None Found]

Source Information:

All Sources	23 Source Document(s)
Motor Vehicle Registrations	8 Source Document(s)
Person Locator 1	1 Source Document(s)
Voter Registrations	1 Source Document(s)
Phone	3 Source Document(s)
Historical Person Locator	4 Source Document(s)
Person Locator 2	4 Source Document(s)
Person Locator 4	2 Source Document(s)